BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MARCIA KAY MCCULLEY 1014 South Westlake Boulevard #14-182 Westlake Village, CA 91361 Registered Nurse License No. 429440 Public Health Nurse Certificate No. 49428 Nurse Practitioner Certificate No. 9578 Nurse Practitioner Furnishing Certificate No. 9578 Respondent.	Case No. 2007-249

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on January 15, 2008.

IT IS SO ORDERED this January 15, 2008.

LaFrancene W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

1015-53

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First-Amended Accusation Against: MARCIA KAY MCCULLEY 2950 N. Sycamore Dr. #201 Simi Valley CA, 93065 Registered Nurse License No. 429440 Nurse Practitioner Certificate No. 9578 Nurse Practitioner Furnishing Certificate No. 9578 Public Health Nurse Certificate No. 49428 Respondent.	Case No. 2007-249 OAH No. L-2007010454 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Complainant Ruth Ann Terry, M.P.H., R.N., is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Anne Hunter, Deputy Attorney General.

2. Respondent Marcia Kay McCulley aka Marcia Kay Hansen is represented

in this proceeding by attorney Jonathan H. Rose, Esq., whose address is 3555 Fifth Avenue, Suite 100, San Diego, CA 92103.

3. On or about August 31, 1988, the Board of Registered Nursing issued Registered Nurse License No. 429440 to respondent. The Registered Nurse License was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

4. On or about December 19, 1997, the Board of Registered Nursing issued Nurse Practitioner Certificate No. 9578 to respondent. The Nurse Practitioner Certificate was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

5. On or about July 31, 1998, the Board of Registered Nursing issued Nurse Practitioner Furnisher Certificate 9578 to respondent. The Nurse Practitioner Furnisher Registration was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

6. On or about September 4, 1992, the Board of Registered Nursing issued Public Health Nurse Certificate No. 49428 to respondent. The Public Health Nurse License was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

JURISDICTION

7. On April 17, 2006, complainant filed Accusation No. 2006-186 against respondent. On October 17, 18 and 19, 2006, a hearing was held on the accusation. On December 11, 2006, a proposed decision was issued. On February 22, 2007, the Board issued a Notice of Nonadoption of the Proposed Decision. On July 3, 2007, after having reviewed the administrative record including the transcript, exhibits, and written argument from both parties, the Board rendered its decision in the matter finding respondent had violated various provisions of the Nursing Practice Act, revoked her 4 licenses, immediately stayed the revocation order, and placed respondent on 5 years probation under specified terms and conditions. A copy of the

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Board's Decision and Order, effective August 2, 2007, is attached hereto as exhibit A and incorporated herein by reference as though fully set forth.

8. On January 17, 2007, complainant filed a petition for interim suspension order. On January 23, 2007, the interim suspension order issued. The order was served on respondent on January 25, 2007, by overnight mail. The order suspended respondent's four licenses referenced in paragraphs 3, 4, 5 and 6 above pending the final resolution of Accusation No. 2007-249. A copy of the Interim Suspension Order in OAH Case No. L2007010454 is attached hereto as exhibit B and incorporated herein by reference.

9. On March 29, 2007, Accusation No. 2007-249 was filed before the Board of Registered Nursing, and is currently pending against respondent. The accusation and all other statutorily required documents were properly served on respondent on April 2, 2007. Respondent timely filed her notice of defense contesting the accusation. A copy of Accusation No. 2007-249 is attached as exhibit C and incorporated herein by reference.

10. On August 14, 2007, First-Amended Accusation No. 2007-249 was filed before the Board of Registered Nursing, and is currently pending against respondent. The first-amended accusation and all other statutorily required documents were properly served on respondent on August 14, 2007. A copy of First-Amended Accusation No. 2007-249 [hereinafter referred to as the "accusation" or "Accusation No. 2007-249"] is attached as exhibit D and incorporated herein by reference.

ADVISEMENT AND WAIVERS

11. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in Accusation No. 2007-249. Respondent has also carefully read, discussed with counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

12. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of

subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

13. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

14. Respondent admits the truth of each and every charge and allegation in Accusation No. 2006-186.

15. Respondent understands and agrees that the charges and allegations in First-Amended Accusation No. 2007-249, if proven at a hearing, constitute cause for imposing discipline upon her Registered Nurse License No. 429440, Nurse Practitioner Certificate No. 9578, Nurse Practitioner Furnishing Certificate No. 9578, and Public Health Nurse Certificate No. 49428.

16. For the purpose of resolving First-Amended Accusation No. 2007-249 without the expense and uncertainty of further proceedings, respondent agrees that, at a hearing, complainant could establish a factual basis for the charges in First-Amended Accusation No. 2007-249 and that those charges constitute cause for discipline. Respondent hereby gives up her right to contest that cause for discipline exists based on those charges.

17. Respondent understands that by signing this stipulation she enables the Board of Registered Nursing to issue an order accepting without further process the surrender of her Registered Nurse License No. 429440, Nurse Practitioner Certificate No. 9578, Nurse Practitioner Furnishing Certificate No. 9578, and Public Health Nurse Certificate No. 49428.

RESERVATION

18. The admissions made by respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Board of Registered Nursing or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

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CONTINGENCY

19. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by respondent. By signing the stipulation, respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender of License and Order shall be of no force or effect; except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

OTHER MATTERS

20. Respondent hereby waives her right to appeal the Board's Decision and Order in Accusation Case No. 2006-186, effective August 2, 2007. A copy of that decision and order is attached hereto as exhibit A and incorporated herein by reference.

21. The parties understand and agree that the Interim Suspension Order issued on or about January 23, 2007, in OAH CASE NO. L2007010454, shall remain in effect until the Board's decision and order in OAH CASE NO. L2007010454, Board of Registered Nursing Case No. 2007-249, is final.

22. Upon the effective date of the Board's adoption of this stipulated surrender as its Decision and Order in this matter, respondent shall no longer be subject to the Board's Decision and Order in Accusation Case No. 2006-186, and Accusation No. 2006-186 shall be incorporated by reference into this stipulated agreement with Accusation No. 2007-249 and First-Amended Accusation No. 2007-249.

23. The parties understand and agree that respondent shall surrender to the Medical Board of California her Licensed Midwife Certificate No. LM 134, issued to her by that Board on or about August 21, 2001, and provide proof to the Board of Registered Nursing within 30 days of the effective date of the adoption of this stipulated surrender of license and order that she has surrendered her Midwife Certificate No. LM 134 to the Medical Board.

24. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

25. In consideration of the foregoing admissions and stipulations, the parties agree that the Board of Registered Nursing may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 429440, Nurse Practitioner Certificate No. 9578, Nurse Practitioner Furnishing Certificate No. 9578, and Public Health Nurse Certificate No. 49428 issued to respondent Marcia Kay McCulley aka Marcia Kay Hansen are surrendered and accepted by the Board of Registered Nursing.

1. The surrender of respondent's Registered Nurse License No. 429440, Nurse Practitioner Certificate No. 9578, Nurse Practitioner Furnishing Certificate No. 9578, and Public Health Nurse Certificate No. 49428 and the acceptance of the surrendered licenses by the Board of Registered Nursing shall constitute the imposition of discipline against respondent. This stipulation constitutes a record of the discipline and shall become a part of respondent's license history with the Board of Registered Nursing.

2. Respondent shall lose all rights and privileges as a Registered Nurse, Nurse Practitioner and Public Health Nurse in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board both her pocket licenses and her wall certificates on or before the effective date of the Decision and Order.

4. Respondent fully understands and agrees that if she ever files an application for licensure or a petition for reinstatement in the State of California, the Board of Registered Nursing shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2006-186

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and First-Amended Accusation No. 2007-249 shall be deemed to be true, correct and admitted by respondent when the Board determines whether to grant or deny the petition.

5. Should respondent ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 2006-186 and First-Amended Accusation, No. 2007-249 shall be deemed to be true, correct, and admitted by respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

6. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board's Decision and Order.

7. Respondent shall pay to the Board the costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of Ten Thousand Dollars and No Cents ($10,000.00) prior to issuance of a new or reinstated license.

8. Respondent shall surrender to the Medical Board of California her Licensed Midwife Certificate No. LM 134, issued to her by that Board on or about August 21, 2001. Respondent shall provide proof to the Board of Registered Nursing within 30 days of the effective date of the adoption of this stipulated settlement and disciplinary order that she has surrendered her midwife certificate No. LM 134 to the Medical Board.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Jonathan H. Rose, Esq. I understand the stipulation and the effect it will have on my Registered Nurse License No. 429440, Nurse Practitioner Certificate No. 9578, Nurse Practitioner Furnishing Certificate No. 9578, and Public Health Nurse Certificate No. 49428. I enter into this Stipulated Surrender of License and Order voluntarily,

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knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 11-26-07

Marcia Kay McCulley
Respondent

I have read and fully discussed with Respondent Marcia Kay McCulley the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 11/26/07

JONATHAN H. ROSE, ESQ.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing.

DATED: Nov 26, 2007

EDMUND G. BROWN JR., Attorney General
of the State of California

MARC D. GREENBAUM
Supervising Deputy Attorney General

ANNE HUNTER
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: LA2007600568
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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MARCIA KAY MCCULLEY 2950 N. Sycamore Dr. #201 Simi Valley CA, 93065 Registered Nurse License No. 429440 Nurse Practitioner Certificate No. 9578 Nurse Practitioner Furnishing Certificate No. 9578 Public Health Nurse Certificate No. 49428 Respondent.	Case No. 2007-249 OAH No. L-2007010454

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, as its Decision in this matter.

This Decision shall become effective on January 15, 2008.

It is so ORDERED January 15, 2008.

La Francine Tate

FOR THE BOARD OF REGISTERED NURSING

Exhibit A

Decision and Order After Non-Adoption No. 2006-186

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MARCIA KAY MCCULLEY, a.k.a. MARCIA KAY HANSEN 2950 N Sycamore Drive, # 201 Simi Valley, CA 92065 Registered Nurse License No. 429440 Nurse Practitioner Certificate No. 9578 Nurse Practitioner Furnisher Certificate No. 9578 Public Health Nurse Certificate No. 49428 Respondent.	Case No. 2006-186 OAH No. L2006060339

DECISION AFTER NON-ADOPTION

On October 17, October 18 and October 19, 2006, in Los Angeles, California, Perry O. Johnson, Administrative Law Judge, Office of Administrative Hearings (OAH), heard this matter.

Anne Hunter, Deputy Attorney General, represented Complainant Ruth Ann Terry, M.P.H., R.N., Executive Officer, Board of Registered Nursing, Department of Consumer Affairs (Complainant).

Respondent Marcia Kay McCulley, also known as Marcia Kay Hansen, (Respondent) appeared at the proceeding, but she was not otherwise represented.

At the hearing of this matter, under the authority of Government Code section 11507, Complainant made a motion, which was granted, to amend the Accusation as follows: (1) on page 1, line 27, and page 2, lines 4, 8 and 12, the date of "March 31, 2006" is changed to "March 31, 2008;" (2) on page 12, at lines 11 through 16, the text of the Accusation is deleted so as to expunge the Tenth Cause for Discipline; (3) on page 5, at lines 11, 17, and 23, change the designation "nurse-midwife" to "nurse/lay midwife;" and (4) on page 12, add a newly pled Cause for Discipline, which would be numbered as the Eleventh Cause for Discipline, and that reads as follows, "Respondent is subject to disciplinary action under section 2762, subdivision (a), for unprofessional conduct of a person licensed under this chapter to obtain or possess in violation of law, or prescribe or furnish to another, except as directed by a licensed physician and surgeon, any controlled substance, as defined in

Division 10, (commencing with section 11000) of the Health and Safety Code, or dangerous drug, as defined in Section 4022 of the Business and Professions Code."

The record was held open to afford an opportunity to Complainant to file an affidavit by the Custodian of Medical Records for Simi Valley Hospital that pertained to documents presented at the hearing. On October 26, 2006, OAH received the Affidavit of Ms. Jennifer Heimer, Custodian of Medical Records for the subject hospital. Also the record was held open to give an opportunity to Complainant to file an amended certification of costs under Business and Professions Code section 125.3 that would recite the bases upon which Respondent might be required to pay the Board of Registered Nursing the reasonable costs of investigation and prosecution of the allegations set out in the accusation against Respondent. Complainant was given a due date of Friday, October 27, 2006, to file with OAH, and to serve on Respondent, the amended certification of costs. Also the record was held open to provide Respondent time to prepare a written objection, if any, to Complainant's petition for an order for recovery of costs of investigation and prosecution. Respondent was given a due date of Wednesday, November 8, 2006, to file with OAH, and to serve on Complainant's counsel, a written objection to the reasonableness of Complainant's cost certification. On Thursday, October 26, 2006, OAH received from Complainant's counsel an amended certification of costs. After receiving Complainant's amended certification, the record remained opened for an additional 13 calendar days in order to afford Respondent the chance to file with OAH a written argument that set out objections to the reasonableness of the costs that Complainant sought to have Respondent pay to the Board. By Wednesday, November 8, 2006, [1]OAH had not received from Respondent a written objection to Complainant's amended certification of costs.

On November 9, 2006, the parties were deemed to have submitted the matter, and the record closed.

Administrative Law Judge Perry O. Johnson issued his Proposed Decision on December 11, 2006. On February 22, 2007, the Board of Registered Nursing ("Board") issued a Notice of Nonadoption of the Proposed Decision. On April 2, 2007, the Board issued its Order Fixing Date for Submission of Written Argument. After having reviewed the administrative record including the transcript, exhibits, and written argument from both parties, the Board hereby renders the following decision in this matter.

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1 On Tuesday, November 14, 2006, OAH received a letter, dated November 7, 2006, by Respondent. The letter was marked for identification as Respondent's exhibit "N." However, for two reasons the letter was not received for consideration by OAH as Respondent's written objection and argument regarding Complainant's amended certification to recover costs of investigation and prosecution. First, Respondent's letter was tardy by one week. Second and more important, Respondent's letter included neither an indication on the letter of "cc" nor an attached proof of service to establish that the correspondence was served upon Complainant's counsel.

FACTUAL FINDINGS

1. On April 17, 2006, in her official capacity as Executive Officer, Board of Registered Nursing, Department of Consumer Affairs, State of California, Ruth Ann Terry, M.P.H., R.N. (Complainant) filed Accusation number 2006-186 against Respondent Marcia Kay McCulley, also known as Marcia Kay Hansen (Respondent).

On May 18, 2006, Respondent executed a Notice of Defense and requested a hearing to present a defense to the charges contained in the Accusation.

On July 10, 2006, Complainant's counsel mailed Respondent a Notice of Hearing that set the administrative adjudication to commence on October 17, 2006.

License History

2. On August 31, 1988, the California Board of Registered Nursing issued Registered Nurse License number 429440 to Respondent.

On September 4, 1992, the Board issued Public Health Nurse Certificate number 429440 to Respondent.

On December 19, 1997, the Board issued Nurse Practitioner Advanced Certificate number 9578 to Respondent.

On July 31, 1998, the Board issued Nurse Practitioner Furnishing Advanced Certificate number 9578 to Respondent.

The licenses and certificates issued to Respondent by the Board were in full force and effect at all times relevant to the matters set out below.

3. Respondent's Registered Nurse License, Public Health Nurse Certificate, Nurse Practitioner Certificate, and Nurse Practitioner Furnisher Certificate will expire on March 31, 2008, unless revoked, surrendered or renewed before that date.

4. The Medical Board of California, on August 21, 2001, issued Respondent a certificate as a professional certified midwife (lay-midwife). However, the Board of Registered Nursing has never issued license status to Respondent to act as a certified nurse-midwife (CNM).

Complainant's Investigator

5. Mr. Broughton O'Keefe (Mr. O'Keefe) is an investigator with the Division of Investigation of the Department of Consumer Affairs.

By his demeanor while testifying, by his detached professionalism, by his attitude towards the proceeding, and by the consistency of his testimony, Mr. O'Keefe showed that he was a credible and [2] persuasive witness at the hearing of this matter.

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2 Business and Professions Code section 11425.50, subdivision (b), third sentence.

6. In mid-2003, Mr. O'Keefe began an investigation of complaints against Respondent as brought to the Board by a law firm that represented the interests of Simi Valley Hospital and Health Care Services (Simi Valley Hospital).

After being assigned to the matter that involved complaints against Respondent, Mr. O'Keefe conducted an extensive investigation that involved conducting interviews with Respondent as well as one of Respondent's patients. Mr. O'Keefe also secured a comprehensive overview of documents that recorded the concerns and problems encountered by physicians with Simi Valley Hospital regarding treatment provided women who had first been patients at the midwifery facility operated by Respondent. Mr. O'Keefe, by way of a lawful investigative administrative subpoena, procured voluminous medical records from both Simi Valley Hospital and Respondent's business premises.

7. On March 12, 2004, Mr. O'Keefe interviewed Respondent. During the course of the investigatory interview, Respondent made admissions to Mr. O'Keefe. She stated, among other things: 1) that she did not have a single identifiable supervising physician within the meaning of the statute and Board regulations. But, she did have a medical doctor who agreed to see her patients for mid-trimester ultrasound according to her report. Respondent identified the medical doctor that she then used for consultation as Daryosh Jadali, M.D. Also, she required no supervising physician for her midwifery practice because if emergency OB/GYN complications occurred Respondent could resort to Simi Valley Hospital that was across the street from the premises she used for the provision of midwifery services; 2) that Respondent possessed at her business premises no standardized written procedures or protocol documents for the particularized furnishing of controlled substances or dangerous drugs to patients under her midwifery practice facility; 3) that in the case of patient J.A., Respondent administered or furnished two grams of Ampicillin; she had no fetal monitoring equipment or ultrasound equipment, but rather used a stethoscope and a waterproof Doppler device to assess the condition of the fetus; Patient J.A. had emotional or mental difficulties at Respondent's facility and the patient did not respond to Respondent's midwife services; after Patient J.A. was eventually transferred to Simi Valley Hospital and after medical intervention with a "C-section" on the patient, a medical doctor confronted Respondent to express displeasure with the three-day lapse of time between the ruptured membrane, which occurred at Respondent's facility, and the time the patient was admitted into the hospital. At that point in time Respondent told Patient J.A.'s attending physician at Simi Valley Hospital that in her opinion it was not unusual or extraordinary for a woman's labor to progress over a course of time as long as seven days; and, 4) that in the case of a second patient, known as Patient R.B., Respondent induced the rupture of Patient R.B.'s membrane, but the patient did not progress appropriately through labor. Respondent called no supervising physician/surgeon to review Patient R.B. during the course of labor, which covered five days, at the premises operated by Respondent. She had an agreement with a medical doctor named Dr. Vehe Azizian, but Patient R.B.'s complications in Respondent's opinion, did not warrant intercession by the medical doctor before the patient was discharged from the midwifery facility operated by Respondent to enter Simi Valley Hospital for an emergency C-section surgical procedure.

The Birthing Center

8. In August 2002, Respondent opened, as her sole business, a facility that provided midwifery services. The facility bore the name The Whole Woman Birthing Center (The Birthing Center). In October 2002, Respondent incorporated the business under the fictitious business name of The Whole Woman, Inc. The Birthing Center's facility, which had its construction completed in March 2003, is located at 2950 North Sycamore Drive, Suite 201, Simi Valley, California 93065.

The Birthing Center consists of approximately three thousand square feet. The facility has two examination rooms, two "birthing" rooms, a kitchen, a waiting room and a laboratory. Each birthing room has furnishings that include a bed and a hydrotherapy pool. (Respondent expended about $50,000 to construct and to equip The Birthing Center.)

Across the street from the premises of The Birthing Center is Simi Valley Hospital.

Patient J.A.

9. In late March 2003, Patient J.A., who was 26 years old, became a patient of Respondent's midwifery practice. When Patient J.A. experienced contractions during the final days of her pregnancy, she and her husband went to the Birthing Center to meet with Respondent. Patient J.A. was a first-time expectant mother.

10. During the mid-afternoon of March 28, 2003, Respondent examined Patient J.A. Respondent concluded that labor was not so imminent as to require the patient to remain at The Birthing Center. Respondent discharged Patient J.A. so that the pregnant woman returned to her residence.

11. Patient J.A. experienced symptoms that she believed to indicate increased labor (frequent contractions and significant pain) so she returned to Respondent's birthing facility. Accompanied by her husband, her mother and a close friend, Patient J.A. returned to The Birthing Center at about 2130 hours (9:30 p.m.) on Friday, March 28, 2003.

Patient J.A. labored until the early morning of March 31, 2003, so that her labor process spanned a period of between 48 hours and 55 hours.

Patient J.A.'s amniotic membranes ruptured at about 0200 hours (2:00 a.m.) on Saturday, March 29, 2003. Patient J.A. began "pushing" at about 0400 hours on March 29, 2003, and continued pushing though March 31, 2003. Respondent furnished Motrin and Darvocet to Patient J.A. to ease the patient's pain.

During the late night of March 30, 2003, Respondent informed Patient J.A. and the patient's husband that the fetus's heartbeat was weak.

12. Up to the point on March 30, 2003, that Patient J.A.'s mother, visiting relatives and husband finally exerted influence and control to end the patient's treatment at The Birthing Center, Respondent attempted to dissuade and discourage Patient J.A. from leaving the Birthing Center in order to seek medical care at the hospital.

13. On the night of Sunday, March 30, 2003, when Patient J.A.'s labor did not progress, which also caused emotional distress to the patient's husband, mother and other family members present at The Birthing Center, the patient was taken from the facility, placed in her husband's car and driven to the Emergency Room of Simi Valley Hospital. Respondent did not accompany Patient J.A. to the hospital, although the patient had been at The Birthing Center about 48 hours to 55 hours.

14. Patient J.A. was admitted to the Simi Valley Hospital at about 0031 hours (12:31 a.m.) on March 31, 2003. The Simi Valley Hospital admission records revealed that when Patient J.A. arrived at the hospital, the fetal heart tones were in the 160s with flat variability and late decelerations. The cervical examination disclosed findings of 10/100/-3 for Patient J.A. Also heavy meconium[3] leaked from Patient J.A.

At the Simi Valley Hospital, the examining physician found the fetus to have a "non reassuring fetal heart tracing." The baby was deemed to be in a condition of "arrest in descent."

The medical doctor performed a pelvic examination on J.A. and found her condition as "fully dilated and effaced, station -3, thick meconium." Hence, at about 0130 hours (1:30 a.m.) on March 31, 2003, an emergency surgical procedure was performed on Patient J.A., which was characterized as a "primary low transverse caesarian section." A surgical pathology report regarding examination of Patient J.A.'s placenta and cord revealed, among other things, "acute chorioamnionitis[4] and acute funisitis;[5] meconium stain of fetal membranes."

15. Even though the physicians at Simi Valley Hospital had noted fetal distress for the baby and Patient J.A.'s uterus had "heavy, thick meconium," with the surgical intervention by medical doctors Patient J.A. delivered a baby boy (six pounds, six ounces, 19 ½ inches long) with "Apgars[6] 7 and 9."

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3 Meconium is waste or fecal matter discharged by the fetus. Complainant's expert witness persuasively stated that medical literature instructs that when a fetus is distressed during delivery process the fetus's anus expels the waste product. Also, meconium is defined as "the first intestinal discharge of a new born infant; greenish in color and consisting of epithelial cells, mucus and bile." (PDR Medical Dict. (1 ed., 1995), p. 1071).

4 "Chorioamnionitis" is an "infection involving the chorion, amnion, and amniotic fluid; usually the placental villi and deciduas are also involved." (id. at p. 334.) "Chorion" is the "multilayered, outermost fetal membrane . . . as pregnancy progresses, part of the chorion becomes the definitive fetal placenta . . . ." (Ibid.) "Amnion" is the "innermost of the extrambryonic membranes enveloping the embryo in utero and containing the amniotic fluid . . . in the later stages of pregnancy the amnion expands to come in contact with and partially fuses to the inner wall of the chorionic vesicle. . . ." (Id. at p. 62.)

5 "Funisitis" is an inflammation of the funis. Funis is a synonym to "umbilical cord." (Id. at p. 695.)

16. During her hospitalization, Patient J.A. showed symptoms of post-delivery depression. A clinical social worker intervened in the patient's care and conducted an inquiry with Respondent about Patient J.A.'s labor at the Birthing Center. Respondent falsely conveyed to the clinical social worker that Patient J.A. chronically was troubled emotionally because she had been abused as a child by her uncle, that is the brother of the patient's mother. When Patient J.A. heard the account given by Respondent to the social worker she suffered additional, emotional upheaval, which is set out further at Factual Finding 85.

Patient R. B.

17. On May 13, 2003, Patient R.B., who was 24 years old, presented herself to Respondent's facility, The Birthing Center. Patient R.B. had been pregnant for about 42 weeks. Because the due date for the patient's delivery had been May 5, 2003, Patient R.B. was about a week past due the delivery when she came under Respondent's provision of midwifery care.

18. Patient R.B had given birth to one child in the year 2000 by Cesarean section surgery. Hence in May, 2003, Patient R.B. sought to be a VBAC (Vaginal Birth After Cesarean) patient.

A patient who is a VBAC patient is not ordinarily expected to be a candidate for a normal, or low risk, delivery. Such patient is generally a high risk patient, who should be expected to have a cesarean section for delivery of a baby because a C-section had been previously performed on the woman. However, such pregnancy may be managed by a mid-wife so long as a supervising physician is readily available for consultation, especially during the labor process.

19. Patient R.B. had a history of Group B Beta Hemolytic Streptococcus (GBS)[7] when she came to The Birthing Center. With GBS, Patient R.B. had a condition that made her a risk against being classified as a patient who would complete a normal labor and delivery course.

20. On May 13, 2003, at about 2030 hours (8:30 p.m.), which was a time when Patient R.B. had a temperature of 101 degrees, Respondent artificially ruptured membranes of the patient.

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6 "Apgars score" is an "evaluation of a newborn infant's physical status by assigning numerical values (0 to 2) to each of five criteria: 1) heart rate, 2) respiratory effort, 3) muscle tone, 4) response stimulation, and 50 skin color; a score of 8 to 10 indicates the best possible condition" and deemed as normal. (Id. at p. 1,585.

7 Group B Beta Streptococcus (GBS) is a naturally occurring organism that lives on the person of some women. Case studies have shown that some babies born to GBS mother have had congenital lung disorders. Also, GBS infection is the leading cause of neonatal sepsis and meningitis. (Star et al., Ambulatory Obstetrics, (3d ed., 1999), "Group B. Beta –Hemolytic Streptococcus," p. 742)

21. On May 13, 2003, after she had taken measures in order to artificially rupture the membrane of Patient R.B., at about 2045 (8:45 p.m.) Respondent contacted physician, Dr. Vehe Azizian, to notify him of the condition of Patient R.B. But, after that single contact with Dr. Azizian, Respondent never again notified or consulted with the purported supervising physician and surgeon about the protracted time Patient R.B. endured during the first phase of labor.

22. On May 14, 2003, at about 0200 hours (2:00 a.m.), when Patient R.B. was "4 to 5 centimeters and at a minus two station," she entered active labor.

23. While Patient R.B. was within the Birthing Center following commencement of labor, Respondent only monitored the fetal heart rate about every 30 minutes.

24. During the time Patient R.B. remained at The Birthing Center, because she had not completely dilated, Patient R.B. never entered the second phase of labor.

25. At about noon on May 15, 2003, Respondent sent Patient R.B. to her residence. The patient remained away from The Birthing Center for about 10 hours without being monitored by a licensed medical care professional such as a registered nurse practitioner who engages in providing midwifery services.

At about 1000 hours (10:00 a.m.) on May 16, 2003, Patient R.B. returned to The Birthing Center. Respondent discharged Patient R.B. to her home at about 1230 hours (12:30 p.m.) on May 17, 2003. On this second occasion of her discharge from The Birthing Center, Patient R.B. remained away from Respondent's facility for about 16 hours.

At about 950 hours (9:50 a.m.) on May 18, 2003, Patient R.B. returned to The Birthing Center. Within an hour of the patient's readmission to The Birthing Center Respondent examined Patient R.B at about 1030 hours. The examination noted the presence of thick meconium.

26. At about 1130 hours (11:30 a.m.) on May 18, 2003, Respondent telephoned the Simi Valley Hospital OB/GYN unit to report that Patient R.B. would be coming to the hospital.

27. At about 1215 hours on May 18, 2003, Patient R.B. transferred her obstetrical care from The Birthing Center to Simi Valley Hospital.

28. On May 18, 2003, when Simi Valley Hospital admitted her, Patient R.B. had maladies that included high fever and chorioamnionitis. The admission note also reflected that Patient R.B. had had a "prolonged rupture of membranes" since May 13, 2003, and that the patient was a "failed VBAC." The admitting medical professional at the hospital noted fetal tachycardia and thick, foul smelling meconium.

Patient R.B. was immediately taken to the operating room. During a cesarean delivery, the treating obstetrician noted Patient R.B. had deep pelvic adhesions. During the course of the surgery, the medical doctor detected the presence of thick, old meconium.

29. Also at the delivery the infant was very sick. Medical doctors initially diagnosed the new-born baby to have neonatal sepsis and meconium aspiration pneumonia. The baby was described as being "slightly limp with cyanosis, poor cry, Apgar scores of 5 . . . ."

After its birth on May 18, 2003, the infant was hospitalized until May 31, 2003, due to an array of disease processes. During the hospital course, the infant had a number of blood cultures taken, a spinal tap, a CT scan of the brain, and an ultrasound of the kidneys and bladder. The infant was born with a form of pneumonia. During the hospital stay, medical doctors found the baby had contracted Serratia Marcescens, an aggressive bacteria, as well as leukocytosis [8].

Respondent's Matters in Mitigation

30. Respondent proclaims that she is a devoted midwife. She subscribes to the MANA (Midwife Association of North America) Statement of Values and Ethics. She believes that midwifery is a "calling," which is like a religious disposition. Respondent expresses that as a midwife she values "women and their creative, life-affirming and life-giving powers . . . ." Respondent compellingly represents that she values her right to practice the art of midwifery, which is an ancient vocation of women. And she adheres to the notion that "the art of midwifery has existed as long as humans have lived on earth."

31. As to Patient J.A., Respondent contends that the entire range of treatment that is alleged to reflect gross negligence should be analyzed in the context of midwifery rather than in the context of a nurse model. Because Patient J.A. was a midwifery client under her care as a professional midwife (i.e., a licensee of the Medical Board), the standard of care was less stringent than the standard applicable to a certified nurse-midwife (a licensee of the Board of Registered Nursing).

32. As to Patient R.B., Respondent argued that the patient had been transferred from Kaiser Hospital which gave The Birthing Center no record that documented the patient as having an extraordinary risk because of her VBAC status or being a Group B Strep patient.

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8 "Leukocytosis" is "an abnormally large number of leukocytes, as observed in acute infections. . . ." (PDR Medical Dict., supra. p. 959.)

Parameter for Analysis of Respondent's Professional Conduct

33. Respondent argues that she is a Professional Certified Midwife (lay midwife) who is licensed by the Medical Board of California. However, hereafter, the analysis and review of Respondent's acts and omissions pertain to her licensure as a registered nurse practitioner who holds oneself as a nurse who specializes, or exclusively engages, in obstetrics and midwifery activities.

Complainant's Expert Witness

34. Complainant called Ms. Erin Herbert Dunn, C.N.M., R.N.P., M.S.N. (Ms. Dunn) as Complainant's expert witness at the hearing that pertains to the accusation against Respondent.

Ms. Dunn is licensed in the State of Tennessee and the State of California as a Registered Nurse. Under the jurisdiction of the State of California, Ms. Dunn is a certified nurse practitioner in the specialty of obstetrics. She holds a drug furnishing certificate in this state. Ms. Dunn has been a California Board of Registered Nursing licensed certified nurse-midwife since February 2000. Since October 1996, she has had her nurse practice associated with Kaiser Permanente OB/GYN Department in San Diego.

35. By her attitude towards the proceeding, by her consistency in analyzing the documents and medical records associated with the complaints against Respondent, and by her demeanor while providing expert witness testimony, Ms. Dunn demonstrated that she was credible and compelling in offering persuasive opinion evidence in this matter.

36. Ms. Dunn offered well-grounded opinions and instructive observations as follows:

- A registered nurse practitioner who acts in the capacity of a nurse-midwife is restricted in providing services only to women who fall within the criteria of having an anticipated "normal child-birth." Normal child-birth connotes a pregnant woman who is approaching labor with no known predispositions to medically-high risk problems and who reasonably can be expected to tolerate and undergo an uncomplicated vaginal delivery. High risk patients might be women who have a history of certain known past illnesses, patients who have had pre-term labor or pre-term births, patients who have had previous uterine surgery such as an earlier "C-section," and other patients with particular on-going disease conditions that should preclude the services of a midwife.

- In order to provide services of a midwife, the licensee may only attend to child-birth procedures and prenatal, intrapartum and post-partum care when under the supervision of a licensed physician and surgeon. Although the physician and surgeon need not be physically present at the facility where the registered nurse practitioner engages in providing midwifery functions

and duties, the medical doctor must be readily available to attend to complications with a woman's labor or birth process.

- The laws, which govern the range of practice of midwifery, require that the licensee must immediately refer to a physician and surgeon all complications that may develop in the case of a pregnant woman.

- A registered nurse practitioner, who engages in providing midwifery services, or a certified nurse-midwife, may not assist childbirth by any artificial, forcible, or mechanical means.

- Before controlled substances, dangerous drugs or certain medical devices may be furnished by a nurse licensee, who engages in providing midwifery services, a written document, which includes standardized procedures and protocols, must be developed by the licensee under the guidance, approval and continued monitoring of a supervising physician and surgeon.

- The practice of a licensed midwife, as regulated by the Division of Licensing of the Medical Board of California under Business and Professions Code section 2507[9] et seq., is nearly identical to the scope of practice of a certified nurse-midwife, as regulated by the Board of Registered Nursing under Business and Professions Code section 2745[10] et seq.

Two Patients under Respondent's Care

37. Expert Witness Ms. Dunn offered comprehensive analysis, insightful observations and persuasive opinions regarding Respondent's breaches of the standards of care that are expected of a registered nurse practitioner who engages in providing midwifery services. Ms. Dunn compellingly surveyed many instances of Respondent's acts and omissions with regard to two patients, who are identified as Patient J.A. and Patient R.B. Ms. Dunn prepared a report,[11] dated February 20, 2005, that showed Respondent's substandard practice acts and omissions regarding the two patients.

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9 Business and Professions Code sections 2505 to 2571 comprise Article 24 (Licensed Midwifery Practice Act of 1993) of the Code's Chapter 5. That chapter pertains to the Medical Practice Act and provides the range of licensed professions and occupations under the jurisdiction of the Medical Board of California. Code section 2507, subdivision (a), provides:

> The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.

10 Business and Professions Code sections 2746 to 2746.8 make up Article 2.5 (Nurse-Midwives) of the Code's Chapter 6 that pertains to "Nursing." Code section 2746.5, subdivision (a), sets forth:

I. Respondent's Gross Negligence and Incompetence Regarding Patient J.A.

Respondent's Unprofessional Acts and Omissions – Ruptured Membranes

38. On Friday, March 28, 2003 at about 830 hours (8:30 a.m.), Patient J.A. began contractions. At about 1530 hours (3:30 p.m.) on that day, Patient J.A. traveled to the Birthing Center, where Respondent examined the pregnant woman. Respondent sent Patient J.A. home. Then at about 2345 hours (9:45 p.m.) on March 28, 2003, Patient J.A. returned to the Birthing Center, where she remained until late on the night of March 30, 2003.

At 0200 hours (2:00 a.m.) on the early morning of March 29, 2003, Patient J.A.'s amniotic membranes, which are the fluid encasements that surround the fetus while in the womb, were ruptured. Patient J.A. entered the active phase of labor at 0230 (2:30 a.m.) on March 29, 2003. She was completely dilated by noon on March 30, 2003.

39. Once a pregnant woman's membranes have ruptured, the prospect of infection is increased as the protection for the woman's uterus and the fetus is absent or breached. So while there is no time frame for the termination of labor, the standard of care for a nurse-wife requires vigilance of the laboring woman's temperature and alertness regarding symptoms of onset of potential infection, which includes monitoring of the fetal heart rate going towards tachycardia, or abnormally accelerated or rapid heart beating, or becoming dramatically slow.

40. Respondent failed to continue ongoing observations of Patient J.A. Respondent should have known that once the membranes ruptured, infection could likely ensue. Respondent's acts and omissions showed she was incompetent and grossly negligent.

Respondent's Unprofessional Acts and Omissions –Fetal Heart Rate

41. When an obstetrics patient enters the first phase of labor, the standard of care requires a registered nurse practitioner who engages in providing midwifery services to monitor fetal heart rate at intervals of about 30 minutes. Once the patient goes into the

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The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.

11 On the second day of the hearing, Respondent unpersuasively claimed that Complainant had failed or refused to provide Respondent with a copy of the report by Complainant's Expert Witness, Ms. Dunn, in accordance with a discovery request made under Government Code section 11507.6. Complainant's counsel had no log of the titles of the several hundred pages of document that were sent from offices of the Department of Justice to Respondent, but the deputy attorney general made a persuasive argument that the February 2005 report by the expert witness had been mailed to Respondent. In light of Respondent's strenuous protestations, she was offered a remedy of having a continuance in the proceedings for several weeks in order: to thoroughly review the report, hire her own expert witness, and to have Complainant's expert witness return on a date several weeks in the future to undergo cross-examination by Respondent. But, Respondent declined the opportunity for a continuance of the proceedings. Accordingly, her motion was denied to exclude from evidence the expert witness's report and to strike the opinion testimony given by Ms. Dunn.

second phase of labor and the laboring woman is "pushing," the standard of care for a registered nurse practitioner who engages in providing midwifery services requires fetal monitoring every five minutes, at a minimum.

Patient J.A. became completely dilated at about noon on March 30, 2003. At that point, the standard of care required Respondent to monitor the fetal heart rate at intervals, at least, of every five minutes.

At the time Patient J.A. was in labor, The Birthing Center's equipment did not include an electronic fetal heart monitor. Respondent's records do not show that she used, within the time prescribed by industry standards, a manual instrument to timely monitor the heart rate for Patient J.A.'s pregnancy. Respondent failed to place Patient J.A. on electronic fetal monitoring or otherwise use a device to monitor the fetal heart rate.

The average length of time for active labor for a "first time mother" is eleven hours. Respondent prompted Patient J.A. to labor for about 55 hours. That span of time was far in excess of the average time for a similarly situated patient.

42. Respondent should have known that fetal monitoring was essential due to the fetal risk that is associated with prolonged second stage labor.

Respondent's acts and omissions in failing to vigilantly monitor the fetal heart rate of the baby of Patient J.A. showed she was incompetent and grossly negligent as a registered nurse practitioner, who engaged in providing midwifery services.

43. The standard of care for a registered nurse practitioner who engages in providing midwifery services requires the nurse to closely monitor a woman in labor as well as the fetus so as to safeguard, among other things, against onset of infection.

Respondent failed to provide the level of monitoring of Patient J.A.'s fetus in a manner that her acts and omissions reflected her incompetence and gross negligence as a registered nurse practitioner, who engaged in providing midwifery services.

Respondent's Unprofessional Acts and Omissions–Management of Second Phase of Labor and the Duration of Labor of Patient J.A. at The Birthing Center

44. The standard of care requires a registered nurse practitioner, who provides midwifery services, to recognize the length of the second stage of labor, which is the active pushing phase, for a "first-time mother" to be excessive after a period of two hours to three hours. After that period, professional standards require an evaluation to ascertain whether it remains safe for the laboring woman to continue pushing or that delivery should be medically or surgically induced. At that point of evaluation, a registered nurse practitioner who engages in providing midwifery services is required to consult with a physician and surgeon regarding the prospect of medical complications being factors in the delivery process.

When Patient J.A. had been in the active phase of labor for many hours, Respondent did not consult with a physician and surgeon. Patient J.A. had pushed from noon until 2315 hours (11:15 p.m.), when she entered Simi Valley Hospital, which was a period of more than eleven hours. When Patient J.A. was pushing for more than eleven hours, her condition fell outside the realm of normal childbirth. A normal childbirth involves ordinarily the descent of the baby's head with each push. When Patient J.A. pushed for nearly 11 hours, a reasonably competent registered nurse practitioner who engages in providing midwifery services should have known that a complication had arisen in the delivery process so that a physician-surgeon's intervention was required.

Additionally, the average time for labor, including all phases of labor to the moment of delivery, is about 12 hours. The outermost reasonable time for all labor is 26 hours. In the case of Patient J.A., the subject patient's labor process spanned more than 48 hours under Respondent's care at the Birthing Center. The standard of care required Respondent to consult with a supervising physician and surgeon when Patient J.A.'s labor reached the 26-hour point when the baby had no "advancement in station."

Respondent's management of Patient J.A.'s second stage labor involved Respondent's acts and omissions showed an extreme departure from the standard of care expected of a registered nurse practitioner, who may be engaged in providing midwife services.

Respondent failed to manage Patient J.A.'s second phase of labor, and allowed the laboring woman to endure an unreasonably excessive period of labor when the fetus was not progressing towards delivery, in such a manner that her acts and omissions reflected her incompetence and gross negligence as a registered nurse practitioner, who engaged in providing midwifery services.

Respondent's Unprofessional Acts and Omissions--Totality of Care for Patient J.A.

45. Respondent's overall treatment of Patient J.A. fell below the standard of care that, under similar circumstances, a competent registered nurse would ordinarily have provided the patient. With regard to the overall provision of care for Patient J.A., Respondent, as a registered nurse practitioner who engages in providing midwifery services, committed acts and omissions that demonstrated an extreme departure from the standard of care expected of a Board license.

46. When Patient J.A.'s labor far exceeded a reasonable range of time, her condition went outside the scope of a normal childbirth. The standards of the profession of registered nurse practitioner who engages in providing midwifery services require that when a normal childbirth condition does not exist, a physician-surgeon must attend to the patient. When Respondent did not consult a supervising physician after Patient J.A. labored for an excessive time at The Birthing Center, Respondent showed that she was incompetent as a registered nurse practitioner who engages in providing midwifery services.

Respondent failed to attend to the over-all care and treatment of Patient J.A. in such a manner that her acts and omissions reflected her incompetence and gross negligence as a registered nurse practitioner, who engages in providing midwifery services.

Practicing Without Supervision of a Licensed Physician and Surgeon – Patient J.A.

47. When Respondent provided midwife services at the Birthing Center by attending to the case of a childbirth to Patient J.A. at the point in time when the laboring woman experienced an unnecessarily long second phase of labor without the supervision of a licensed physician and surgeon, Respondent worked beyond the scope of practice of a registered nurse practitioner who engages in providing midwifery services.

48. Respondent failed to refer patient J.A. to a physician and surgeon when Patient's J.A.'s labor failed to meet criteria accepted as a normal delivery.

In this regard, Respondent's acts or omissions constituted incompetence and gross negligence as a registered nurse practitioner, who engaged in providing midwifery services.

Failure to Refer Complications to Physician – Patient J.A.

49. At the onset of the relationship between Respondent and Patient J.A. along with her husband, Respondent told the couple that if an emergency or complication developed during either the labor process or the actual delivery of a baby that Simi Valley Hospital was directly across the street from The Birthing Center. However, Respondent did not provide the exact name of the medical doctor who agreed to assume responsibility as the supervising physician and surgeon in the case of Patient J.A.

When Patient J.A.'s labor symptoms failed to remain within criteria within the standards of normal child birth, Respondent failed to refer Patient J.A. to a supervising physician and surgeon for the purpose of evaluating the complications that developed in the laboring phases.

In this regard, Respondent's acts or omissions constituted incompetence and gross negligence as a registered nurse practitioner, who engaged in providing midwifery services.

Furnishing or Ordering Controlled Substances or Dangerous Drugs

50. During Patient J.A.'s course of treatment and care at the Birthing Center, Respondent furnished, or ordered drugs or devices for, the patient without the supervision of a physician and surgeon.

Darvocet is a Schedule II controlled substance. It is narcotic analgesic agent that is furnished for pain management. Respondent furnished Patient J.A. with Darvocet, at least, on two occasions, namely on March 28, 2003, at 0030 hours (12:30 a.m.) and March 29,

2003, at 1330 hours (1:30 p.m.). However, the records of the Birthing Center did not include a patient-specific protocol that justified the furnishing Darvocet to Patient J.A.

51. Ampicillin is an antibiotic medication that is used to treat infection. In order to furnish ampicillin, a nurse-wife must have a physician approved, patient-specific protocol for the affected patient. Respondent furnished Patient J.A., ampicillin on about four occasions on March 29 and March 30, 2003. However, the records of the Birthing Center did not include a patient-specific protocol that justified the furnishing of ampicillin to Patient J.A.

52. Respondent had no standardized protocols or procedures that were prepared and implemented under the directive or oversight of a supervising physician and surgeon with regard to Respondent's furnishing of dangerous drugs or controlled substances to patients at The Birthing Center. Even though Simi Valley Hospital was directly across the street from The Birthing Center, which was Respondent's exclusive site for the provision of registered nurse practitioner midwifery services, Respondent had no direct affiliation or association with that hospital so that no single medical doctor at Simi Valley Hospital had any duty or function as the supervising physician and surgeon within the meaning of the laws that regulate a registered nurse practitioner who holds herself out as a midwife and who furnishes controlled substances or dangerous drugs to obstetrics patients.

53. When Respondent furnished dangerous drugs or controlled substances to patients of The Birthing Center, when no standardized procedures or protocols had been created with the oversight and approval of a physician-surgeon, Respondent exceeded the scope of her licensed practice.

54. When Respondent furnished Patient J.A. with Darvocet, which is a controlled substance, without the clear direction and supervision by a licensed physician and surgeon, she violated the law. Respondent's acts and omissions in so furnishing a controlled substance to a patient of The Birthing Center reflected incompetence and gross negligence as a registered nurse practitioner, who engaged in providing midwifery services.

II. Respondent's Gross Negligence and Incompetence Regarding Patient R.B.

55. Patient R.B. was a VBAC patient. With regard to VBAC patients, standards of care, which are imposed upon registered nurse practitioners who engage in midwifery services, require continuous fetal monitoring every 15 minutes when the patient enters the active phase of labor, and continuous fetal monitoring every five minutes during the "pushing" segment of the childbirth process.

In attending to Patient R.B., Respondent failed to provide the requisite, continuous fetal monitoring to the extent expected of a registered nurse practitioner who holds herself out as a midwife.

56. Respondent knew or should have known that Patient R.B had a positive history of having Group B Beta Strep. Standards of care, which are imposed upon registered nurse practitioners who are engaged in midwifery services, require the provision to such an affected patient with intravenous penicillin, or a suitable substitute to penicillin, upon the onset of labor, and every four hours until birth. Respondent failed to administer the proper antibiotic to Patient R.B., a carrier of Group B Beta Strep.

In providing midwifery services to Patient R.B., Respondent failed provide that proper medication, in the proper dosage, by the proper route.

In this regard, Respondent's conduct showed incompetence and gross negligence as a registered nurse practitioner, who engaged in providing midwifery services.

57. While Patient R.B. was within the Birthing Center over a period of five days and when the patient was in the course of labor, only on one occasion did Respondent communicate with a physician – Dr. Azizian.

When Respondent failed to consult with a supervising physician and surgeon, after the single exchange with Dr. Azizian, Respondent's acts and omissions in treating Patient R.B. reflected an extreme departure from the standard of care expected of a registered nurse practitioner who is engaged in providing midwifery services.

58. While she was present at the Birthing Center, Patient R.B. experienced a fever of 101 degrees Fahrenheit. Respondent furnished Patient R.B. Ancef and clindamycin during the course of her labor. Respondent failed to administer the appropriate antibiotic. Such was inappropriate and substandard treatment.

59. Between May 13, 2003, and May 15, 2003, Respondent sent Patient R.B. to her residence. Respondent discharged Patient R.B. with ruptured membranes and the patient entered active labor. On the first occasion that Respondent sent Patient R.B. to her home, there was no fetal monitoring for a period of, at least, 10 hours. On the second instances when Respondent sent Patient R.B. to her residence, the patient was at her home for 16 hours when she was 8cm dilated and had had no cervical change for a period greater than 24 hours.

60. Respondent's over-all treatment of Patient R.B. reflected an extreme departure from the standard of care expected of a competent registered nurse practitioner who is engaged in providing midwifery services.

Furnishing or Ordering Controlled Substances or Dangerous Drugs Without Standardized Procedures or Protocols regarding Patient R.B.

61. Regarding Patient R.B.'s course of treatment and care at The Birthing Center, Respondent furnished or ordered drugs or devices without standardized procedures or protocols that should have been developed by Respondent, as a nurse practitioner, in consultation with a supervising physician and surgeon.

Furnishing or Ordering Controlled Substances or Dangerous Drugs regarding Patient R.B

62. During Patient R.B.'s course of treatment and care at The Birthing Center, Respondent furnished to, or ordered controlled substances or devices for, the patient without the supervision of a physician and surgeon.

Performing Services beyond the Authority of Practice as a Registered Nurse Practitioner in the Case of a VBAC Patient as to Patient R.B.

63. Respondent provided nurse practitioner and lay-midwife services to Patient R.B., which represented work that was beyond the scope of the practice of a nurse/lay midwife, when Respondent attempted to attend to the case of a vaginal birth after cesarean, which is not a case of normal childbirth.

Practicing Without Supervision of a Licensed Physician and Surgeon – Patient R.B.

64. When she provided midwife services at the Birthing Center by attending to the case of a childbirth to Patient R.B. without the supervision of a licensed physician and surgeon, Respondent worked beyond the scope of practice of a registered nurse practitioner who engages in providing midwifery services. Respondent's acts or omissions constituted gross negligence and incompetency.

65. Respondent failed to refer patient R.B. to a physician and surgeon when Patient's R.B.'s labor failed to meet criteria accepted as a normal delivery.

Failure to Refer Complications to Physician – Patient R.B.

66. At the onset of the relationship between Respondent and Patient R.B., Respondent informed the woman that if an emergency or complication developed during either the labor process or the actual delivery of a baby that the Simi Valley Hospital was directly across the street from The Birthing Center. However, Respondent did not provide the exact name of the medical doctor who agreed to assume responsibility as the supervising physician and surgeon in the case of Patient R.B..

67. When Patient R.B.'s labor symptoms failed to remain within criteria within the standards of normal child birth, Respondent failed to refer Patient R.B. to a supervising physician and surgeon for the purpose of evaluating the complications that developed in the laboring phases.

68. The standard of care is breached for a registered nurse practitioner who is engaged in providing midwifery services when after the time of rupture of membrane, the laboring woman is improperly discharged from a facility such as The Birthing Center. When a patient is discharged to her residence, the registered nurse practitioner who engages in providing midwifery services cannot observe the patient for onset of infection. Nor can the

registered nurse practitioner who engages in providing midwifery services monitor the fetal heart rate when a patient is discharged to her residence. And in the instance of a VBAC patient, upon a patient going home, the registered nurse practitioner who engages in providing midwifery services cannot detect that the previous C-section scar has not separated or otherwise caused a complication to occur.

When Respondent discharged Patient R.B. from The Birthing Center to go to her residence, Respondent breached the standard of care expected of a registered nurse practitioner who engages in providing midwifery services.

69. When Patient R.B. spent about five days in only the first phase of labor and she was not progressing towards delivery of a baby, the standard of care required a registered nurse practitioner who engages in providing midwifery services to consult with a supervising physician-surgeon. Because Patient R.B., as a VBAC candidate-patient, did not progress through the labor process in an expected manner, the standard of care required a registered nurse practitioner who engages in providing midwifery services to seek a physician-surgeon's evaluation of the labor process to ascertain the reason or cause for the delay in the labor and to determine whether the patient was a "failed VBAC" patient.

The standard of care requires an ongoing and persistent relationship between the registered nurse practitioner who engages in providing midwifery services and a supervising physician-surgeon. The single contact with a "backup" physician as made by Respondent on one occasion over five days of treatment to Patient does not comply with the standard of care expected of a registered nurse practitioner who engages in providing midwifery services.

70. Respondent's provision of servicing to Patient R.B., through The Birthing Center, with regard to the entire range of treatment given the patient during the first phase of labor, involved an extreme departure from the standard of care expected of a nurse-wife.

Respondent's provision of services to Patient R.B. demonstrated incompetence and gross negligence as a registered nurse practitioner, who engaged in providing midwifery services.

In particular, incompetence was shown when over a period of five days of Patient R.B.'s labor in the first phase, Respondent only contacted the supervising physician on one occasion, that is on May 13, 2003, which was the first day of the patient's stay at The Birthing Center.

Also, incompetence was indicated when after Respondent found febrile, Respondent artificially ruptured the membranes of Patient R.B.

And, incompetence was demonstrated when Patient R.B., being a VBAC candidate, was sent home by Respondent from The Birthing Center for a length of time when the patient was about seven to eight centimeters dilated. And then the patient returned to The Birthing Center only to be sent home a second time. Such patient management is "completely

outside" the standard of care for a registered nurse practitioner who engages in providing midwifery services.

The standard of care requires that a registered nurse practitioner who engages in providing midwifery services administer a regimen of drugs during labor to eliminate the presence of the GBS organism at the time of delivery of the baby. Ordinarily, the treatment regimen includes a loading dose of penicillin, intravenously, at the time of membrane rupturing or onset of active phase of labor, and then to repeat the dosage every four hours until the birth of the baby. When a woman is penicillin allergic, presenting the affected patient with doses of clindanycin or Anfect over the course of labor is not adequate according to the standard of care to shield the baby from the GBS organism.

Respondent furnished Patient R.B., a dose of ampicillin orally for days before onset of active labor and the delivery. However, the standard of care in the profession requires a registered nurse practitioner who engages in providing midwifery services to know that ampicillin does not eradicate the GBS organism at the time of delivery. Ampicillin, by an oral route to the laboring mother, is an inappropriate treatment to shield a baby from the Group Beta Strep organism.

71. Respondent's use of ampicillin in the treatment of Patient R.B., who was a Group Beta Strep carrier, reflected a slight departure from the standard of care expected of a registered nurse practitioner who engages in providing midwifery services.

Respondent's use of ampicillin in treating Patient R.B. demonstrated incompetence as a registered nurse practitioner, who engaged in providing midwifery services.

72. Respondent placed Patient R.B. on oral ampicillin 250mg. from about April 21, 2003, through May 18, 2003. Also Respondent administered Ancef intravenously (IV) for eight hours on three days: May 13, May 14 and May 15, 2003. And Respondent furnished Patient R.B. with two doses of clindamycin 900mg. intravenously for eight hours on May 16, 2003.

Respondent used the Ancef intravenously and clindamycin to purportedly control infection after the artificial rupturing of the membranes of Patient R.B. But the standard of care required use of gentamicin to treat a form of infection causing bacterium that Patient R.B. was susceptible to contracting during the course of labor.

Respondent's omission in furnishing Patient R.B. with the drug gentamicin, but rather furnished the patient with two inappropriate drugs to ward off infection, demonstrated the provision of care that was outside the standard of care expected of a registered nurse practitioner who engages in providing midwifery services. Such omission reflected an extreme departure from the standard of care expected of a registered nurse practitioner, who engaged in providing midwifery services.

73. Patient R.B. was discharged on two separate instances despite her high risk status and that she was in active labor. On the first occurrence of being "sent home," Patient R.B. was eight centimeters dilated with a ruptured "bag of water" and then went 10 hours without fetal monitoring. Respondent sent Patient R.B. home for 16 hours with no cervical change over a span of 24 hours when the patient was eight centimeters dilated. Respondent's acts and omissions in this regard reflected an extreme departure from the standard of care as a registered nurse practitioner, who engaged in providing midwifery services.

74. When Respondent furnished Patient R.B. with a controlled substance, without the clear direction and supervision by a licensed physician and surgeon, she violated the law. Respondent's acts and omissions in so furnishing a controlled substance to a patient of The Birthing Center reflected incompetence and gross negligence as a registered nurse practitioner, who engaged in providing midwifery services.

Respondent's Background and Matters in Mitigation

75. In addition to acquiring the license and certificates mentioned in Factual Finding 2 above, Respondent has secured over the years other credentials and certificates as follows: 1991–Perinatal Nursing designation by the American Nurses Credentialing Center; 1997–Women's Healthcare Nurse Practitioner certificate from Harbor-UCLA; 1999–Drug Enforcement Administration (DEA) authorization certificate; and, 2002–Certified Nurse of the Operating Room (CNOR).

On August 14, 2001, the California Medical Board issued Respondent licensure as a certified professional midwife (lay midwife). She holds license number 134 as a lay midwife.

76. Respondent graduated with an Associate Degree in Nursing from the Pacific Union College in Angwin (Napa County), California on June 12, 1988. She earned a Bachelor of Science Degree in Nursing from Pacific Union College.

In 1992, Respondent attended the University of La Verne in La Verne, California. During that year, she transferred to California State University Long Beach to enroll in a master's degree program.

In 1996 and 1997, Respondent enrolled in an intensive internship in obstetrics and midwifery practice.

In 2001, Respondent completed the California Medical Board's Challenge Process. In 2002, she completed the RN First Assisting Program at UCLA. And in 2004, Respondent enrolled in the University of Phoenix's Master's Degree in Nursing program.

77. Respondent has concentrated, or specialized, in Obstetrics/Gynecology medicine for her entire nursing career, which spans more than 18 years.

78. Respondent is a member of various professional organizations and associations that include: American College of Obstetrics and Gynecology; Association of Operating Room Nurses; Association of Women's Health, Obstetrics and Neonatal Nursing for which she has been an Instructor/Trainer for Principles and Practices of Fetal Monitoring course; California Association of Licensed Midwives; California Association of Midwives; National Association of Childbearing Centers; Association for Nurse Practitioners in Women's Health; Midwifery Alliance of North America; Perinatal Advisory Council for Leadership, Advocacy and Consultation.

79. Before opening The Birthing Center, Respondent had worked more than seven years as a labor/delivery nurse. Respondent had been a surgery room nurse for one year in the past before beginning her business as a midwife. She had been a nurse practitioner, who worked with a medical doctor in a sole practice, for six years. She had been a nursing supervisor in a local labor and delivery hospital for nine months during a nurse labor strike.

80. The two matters that underpin the accusation against Respondent, which pertain to Patient J.A. and Patient R.B., were among the first handful of women who sought to deliver babies at The Birthing Center. She is not proud of the outcome in the two matters; however, Respondent believes that her decision-making was well founded. In 2003, she was a new midwife in a self-employed, private business capacity. Respondent had extensive experience in a traditional medical model so that she had a great learning curve in making the switch to the alternative health care model in the context of The Birthing Center.

81. Respondent compellingly proclaimed at the hearing of this matter that the Medical Board of California has appointed her to act as an industry expert in the realm of midwifery to assess the practice skills of other certified professional midwifery practitioners who are licensed under Business and Professions Code section 2505 et seq. She recalls that she has analyzed or reviewed five separate cases that concerned certified professional midwife (lay-midwife) practitioners who were all located in Northern California counties. But, Respondent did not produce any letter from the California Medical Board to corroborate her appointment as an industry expert of lay midwife issues.

As a lay-midwife licensee of the Medical Board, Respondent has developed documents, titled "Midwifery Care Checklist"; "Consent for Midwifery Services"; "Licensed Midwife Disclosure Form; " "Prenatal Flow Record;" and "Initial Pregnancy Profile";[12] "Health History Summary/ Maternal-Newborn Record System."[13] The forms enable her to conduct an efficient and safe environment for the provision of midwifery services.

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12 The "Licensed Midwife Disclosure Form" includes a provision that reads: "The specific arrangements for the transfer of care during prenatal period, hospital transfer during the intrapartum and postpartum periods, and access to appropriate emergency medical services for both the mother and the baby, if necessary, have been described."

13 The Health History Summary had a section for recording the name of "Primary/Referring Physician."

Over an unknown span of time, Respondent assembled a list of thirty-one names of medical doctors who appear on a document titled, "Supervising/Collaborating/Referral Physicians for Marcia McCulley, NP [nurse practitioner], LM [lay midwife]." However, Respondent offered no evidence as to the accuracy of the list in that she offered no affidavit or authenticable correspondence from any of the named medical doctors to describe the exact scope of the supervision offered Respondent as the proprietor of The Birthing Center. Moreover, there is no indication as to which physicians were "referring" medical doctors versus acting as Respondent's "supervising" physicians and surgeons. Moreover, Respondent offered no competent evidence regarding the meaning of "collaborating" physicians.

In her capacity as a lay midwife, who is licensed by the Medical Board, Respondent has developed a "resource list" of medical textbooks, guidelines and desk reference volumes that she has designated her "Standardized Protocols." But, Respondent offered no competent evidence that the textbooks have been approved by a licensed medical doctor for use by a midwife practitioner, nor was Respondent convincing or persuasive that such "resource list" was actually created by her before the time that she attended to Patient J.A. and Patient R.B.

82. Although Respondent conducted her first delivery at The Birthing Center in January 2003, her practice as a midwife has grown.

She has had the following number of patients over the past few years.

Year	Number of Patients
2003	22
2004	28
2005	48
2006 to 10/2006	More than 50

During the year 2006, she has performed four to six deliveries per month. August 2006 was her busiest month for The Birthing Center when Respondent handled nine deliveries.

Matters in Aggravation

Credible and Compelling Evidence of Husband of Patient J.A.

83. Mr. D.T. testified at the hearing. He is the husband of Patient J.A.

Mr. D.T. compellingly and persuasively provided testimony regarding the dealings of Respondent with regard to his wife and him. By his demeanor while testifying, by the sincerity and depth of emotion regarding the anguish and stress encountered in the relationship with Respondent, and by his attitude towards the proceeding, Mr. D.T. demonstrated that he is credible in this matter.

84. Mr. D.T. and his wife contemplated alternative birth processes when the couple discovered the wife was pregnant with her first child. Mr. D.T. discovered Respondent's midwife services by way of the Internet. In mid-December 2002, the couple met with Respondent and committed to turn to the Birthing Center when the wife's labor process began.

On Sunday, March 30, 2003, Mr. D. T. observed his wife undergo an ordeal where she expressed intense pain. By late Sunday when Patient J.A. had spent two nights in labor under Respondent's midwifery care, Mr. D.T. heard his wife scream that she believed that she should leave The Birthing Center so as to gain admission to the hospital. Even though Patient J.A. was in agony into Sunday, March 30, Respondent yelled out commands to Patient J.A. to the effect, "You need to have this baby! Come on your need to get serious! Push!" Mr. D.T. observed his wife push to a point where she screamed and then became "out of it." He noted his wife's whites-of-the-eye had become exceedingly red, and he later learned from a treating physician that small blood vessels burst in the laboring woman's eyes. Also late on March 30, 2003, Respondent told Patient J.A. and Mr. D.T. that the baby's heart rate was weak.

During the three days of Patient J.A.'s labor process, Mr. D.T. never heard Respondent suggest that her care be transferred to a medical doctor or that the laboring woman be admitted to Simi Valley Hospital.

Late on Sunday, March 30, 2003, Mr. D.T.'s brother and sister-in-law came to The Birthing Center to visit Patient J.A. The protestations of Mr. D.T.'s relatives and the mother of Patient J.A. alerted Mr. D.T. to the seriousness of his wife's situation. Mr. D.T. took it upon himself to take his wife from The Birthing Center and transport her to Simi Valley Hospital. At the hospital, Patient J.A. was in a state of near delirium.

Respondent did not accompany Patient J.A. to the Simi Valley Hospital to facilitate her admission to the hospital. Respondent felt that Patient J.A. should have remained at The Birthing Center.

Even though Mr. D.T. understood that a terms and conditions of the midwifery agreement of Respondent included the registered nurse's promise to bring Patient J.A.'s laboring process under a supervising physician on staff at Simi Valley Hospital, Respondent at no time identified the medical doctor who would respond to complications experienced by Patient J.A. But when Patient J.A.'s labor at The Birthing Center failed to progress and Mr. D.T. and his relatives insisted on Patient J.A. going to the hospital, Respondent "did not offer to go to the hospital with [the couple] as [Respondent] earlier agreed in the event of an emergency." Respondent exhibited an attitude of disdain that the couple had elected to leave The Birthing Center. The mother of Patient J.A. directed Respondent to telephone Simi Valley Hospital to inform emergency OB/GYN staff to expect the arrival of Patient J.A.

Upon entering the hospital, Mr. D.T. heard an emergency room physician express that the fetus was in distress in that a slow or weak heart rate was detected. A gross amount of meconium was leaking from Patient J.A. Hospital personnel required Mr. D.T. to sign waiver documents regarding his wife's treatment over the course of several days so as to shield the hospital from liability and then Patient J.A. was rushed into emergency C-section surgery. Mr. D.T. was exasperated with comments by hospital staff regarding the distress experienced by his wife under the care of Respondent's facility, The Birthing Center.

Mr. D.T. heard treating physicians at Simi Valley Hospital say that due to the dimensions of the head of his infant son measured against the size of the birth canal of Patient J.A., the delivery by vaginal birth was highly unlikely to nearly impossible.

Mr. D.T. and Patient J.A. understood after the delivery of their child that Respondent had been unprofessional and incompetent in providing midwifery care to Patient J.A. over a course of more than 50 hours.

85. Beyond the physical and emotional trauma of Patient J.A.'s experience at The Birthing Center, a day after the birth of the couple's infant, Mr. D.T. was shocked by the communication his wife relayed to him, while she was in a state of deep emotional upheaval due to the additional psychic pain injury inflicted by Respondent upon the woman's emotional well-being.

Although he had been with his wife for several hours at the hospital, Mr. D.T. went to the couple's residence for a short duration to "take care of some business." Immediately upon reaching his home, he received a telephone call from his wife's hospital room. His wife, who was hysterical, excitedly proclaimed that a hospital staff social worker had visited with Patient J.A., in the presence of her mother. The social worker told Patient J.A. that Respondent had expressed that Patient J.A. had not fully cooperated in the labor and the delivery had not progressed because Patient J.A. had emotional problems that stemmed from her having been molested as a child by an uncle, that is her mother's brother. When Mr. D.T. heard the account of the social worker's report of Respondent's claim of molestation of Patient J.A., his wife and her mother were deeply upset and emotionally distressed. Neither woman could fathom the rationale for Respondent's statement that was so emotionally hurtful to them.

86. Notwithstanding the gross negligence and incompetence shown by her in providing midwifery services to Patient J.A., Respondent, doing business as The Whole Woman, Inc., through its accounting office, sent Mr. D.T. and his wife a bill for $5,870. (The bill reflected fees for services rendered such as: 3/28/2003-Unspecified Mgmt-$800; 3/28/2003-Medical Services After Hours-$900; 3/29/2003-Night OB Care-$600; /28/2003-Newborn Sundays, Holiday-$300; 3/28/2003-IV Therapy More than 8 Hrs.-$700.)

87. On February 2, 2004, about one year after the provision by Respondent of grossly negligent and incompetent midwifery services to Patient J.A., the accounting representative- Sean McCulley- sent Patient J.A. a dunning letter that threatened to appoint a

collection agency to collect the billing statement amount. The letter conveyed to Patient J.A. that the debt due Respondent would appear on "your credit report for seven years. . . ."

Respondent's Lack of Candor and Honesty

88. Respondent was not truthful and believable in many aspects of her testimony at the hearing of this matter. By her attitude towards the proceedings, by her demeanor while attending the proceeding, by her attitude towards the hearing, and by the inconsistencies between her explanations measured against the existing records and interpretation by Complainant's expert witness, showed Respondent to be neither a credible nor candid witness on various topics, which were developed at the hearing of this matter.

Respondent declared at the hearing that as a midwife she values "honesty in relationship." Yet she was not honest at the hearing of this matter. Most egregious, Respondent blamed Patient J.A. and Patient R.B. as being dishonest themselves in pursuing midwife services with Respondent. However, no competent evidence came from Respondent to establish that the subject patients were not forthright in their roles as patients of The Birthing Center.

Respondent was vague in her attack on the patients as not being honest. And, she only alluded to aspects of the patients that make it difficult for Respondent to practice "the art" of midwifery.

Respondent testified that she never furnished Patient J.A. with Darvocet, but rather the patient personally brought a supply of the medication into the facility. Yet, Respondent's own records show entries that the patient took Darvocet while at The Birthing Center. By the totality of Respondent's self-serving claims and arguments, it may reasonably be inferred that Respondent in fact provided Darvocet to the patient without having proper protocols, and that she gave, at least, misleading testimony at the hearing.

Complainant was not believable when she testified that Patient R.B. developed a temperature of 101 degrees because she went outside The Birthing Center to exercise by walking up and down a set of stairs.

During Complainant's investigator's interview of Respondent, among other things, she stated that she had no standardized procedures and protocols that had been approved by a medical doctor at the time she provided treatment to the subject patients. But at the hearing of this matter, Respondent unpersuasively advanced that she had written protocols, policies and procedures that dated to the Spring of 2003. A reasonable inference is drawn that Respondent did not have such document, which had been created with and approved by a supervising physician and surgeon when Respondent treated Patient J.A. and Patient R.B. Respondent must be viewed as offering misleading and false evidence at the hearing.

Respondent was not compelling when she argued that as a midwife, the art of midwifery does not vest the midwife with a one-side decision-making orientation absent

input from the expectant mother. She was not persuasive by claiming that in the subject cases (Patient J.A. and Patient R.B) decisions regarding the time each laboring woman went to the hospital or sought care from a medical doctor had to flow from both the individual patient and the midwife. The weight of evidence showed Respondent to have exerted an overbearing and dogmatic approach to unduly induce the patients to remain within the confines of The Birthing Center. And only when the affected laboring women were in the state of distress did Respondent send them off to the emergency care of medical doctors at Simi Valley Hospital.

Respondent unpersuasively argued that in the two cases of Patient J.A. and Patient R.B. consideration regarding the length of time for labor in reaching a point of exceeding parameters set by the medical community flowed from a collective decision-making process between the midwife and the patients at The Birthing Center. Measured against the clear description of the duties and functions of a midwife as given by Complainant's expert witness, Respondent's explanations were misleading, incomplete and incorrect.

Lack of Corroborating Evidence from Respondent

89. No competent evidence exists of any good faith effort by Respondent to secure or enlist the services of a medical doctor or medical doctors to act as the responsible supervising physician and surgeon who would approve Respondent's development of written procedures and protocols for the practice of midwifery relative to furnishing controlled substances or dangerous drugs to patients at The Birthing Center.

90. Although Respondent claimed to have a supervising physician and surgeon in the person of a medical doctor named Dr. Vehe Azizian who had agreed to come to the assistance of any laboring woman at The Birthing Center for complications that might manifest during the laboring or delivery processes, Respondent failed to provide a written contract, affidavit or even simple correspondence from Dr. Azizian or any other licensed physician to support her assertion.

Moreover, Respondent proclaimed that she could not enlist the services of any medical doctor who would act as the supervising physician and surgeon to clients of The Birthing Center. A reasonable inference may be drawn that, at least, in the cases of Patient J.A. and Patient R.B., Respondent did not have a supervising physician and surgeon, available to attend to the complications that developed in the instances of the subject patients, within the meaning of either Business and Professions Code section 2507 or section 2746.5.

Other Matters

91. No client, no fellow midwife, no medical doctor came to the proceedings to offer evidence regarding Respondent's reputation in the community for honesty and integrity. No one appeared to offer corroborating testimony regarding Respondent's skills and aptitude as a midwife.

Costs of Investigation and Prosecution

92. Complainant certified that as of October 16, 2006, the following costs were incurred in connection with the investigation of the matters that led to the Accusation against Respondent:

Costs of Investigation Services:

Fiscal Year	No. of Hours	Hourly Rate	Charges
Attorney General			
2005/2006	53.75	$146.00	$7,847.50
2006/2007	64.25	$158.00	$10,151.50
Legal Assistants			
2005/2006	13.00	$92.00	$1,196.00
Division of Investigation			
2003/2004	31.50	$144.00	$4,536.00
2004/2005	2.50	$173.00	$432.50
Expert Witness			
2004/2005	15.00	$75.00	$1,125.00
Total of Investigative, Prosecution and Expert Review:			$25,288.50

93. The Board's exercise of discretion in weighing the assessment or recovery of reasonable costs of investigation and prosecution may be approached with a view towards the following factors:

a. Respondent did not advance a meritorious defense in the exercise of her right to a hearing in this matter. And, Respondent cannot be seen, under the facts set out above, to have committed slight or inconsequential misconduct in the context of the Accusation. And, Respondent did not raise a "colorable challenge" to Complainant's Accusation.

b. Complainant struck one cause for discipline under the Accusation due to failure of proof. With one out of ten causes for discipline expunged, one may reasonably deduct one-tenth of the costs of the cost assessment. Even though an eleventh cause for discipline was added to the Accusation near the conclusion of the proceedings, the

amendment resulted from the evidence developed during the hearing, rather than through pre-trial work of Complainant's investigator, paralegal staff or deputy attorney general.

An entire binder of documentary material was withdrawn by Complainant, which when coupled by activity of the Board's investigator and the paralegal staff of the Department of Justice suggests redundancy in functions and activities, and warrants reduction of another fifteen percent of the costs expended by Complainant. A reasonable deduction from Complainant's costs, therefore, is set at twenty-five percent.

c. Complainant's investigation led to a thorough examination of three patients. However, after Expert Witness Dunn analyzed the extent of Respondent's provision of registered nurse services to midwife patients, only two patient files were prosecuted. The elimination of one of the patient cases is weighed in determining the percentage for reduction of the reasonable cost assessment against Respondent by another five percent.

d. Respondent did not claim that currently she has limited financial resources. To the contrary, by her testimony, Respondent has generated significant revenue from the work as a certified professional midwife. At the hearing, Respondent described her practice as a midwife as having significantly grown in recent years. Respondent expressed that for the current year more than 50 deliveries have occurred at The Birthing Center. She claimed that about four to six babies are born each month at The Birthing Center and that August 2006 was her busiest month as nine babies were born were at Respondent's midwifery facility. The Birthing Center has recorded about 148 births between January 2003 and October 2006. As shown in the records pertaining to services rendered Patient J.A., Respondent billed that patient more than $5,700. If other patients were billed only $5,000 for the provision by Respondent of midwifery services, Respondent's facility has earned $250,000 for the current year-2006. In that Respondent has attended to about 148 births since she began midwifery services at her facility, a reasonable estimate may be inferred that Respondent's midwifery business may have earned gross receipt of about $740,000.

Furthermore, Respondent presented no evidence that she is financially incapable to pay the Board the reasonable costs of investigation and prosecution.

94. In the exercise of the Board's discretion, beyond the reduction of thirty (30%) percent as expressed above, a reasonable basis does not exist to warrant a greater reduction of the assessment against Respondent for the costs of investigation and prosecution incurred by Complainant.

95. Accordingly pursuant to Business and Professions Code section 125.3, Respondent is obligated to pay the Board the costs incurred by Complainant in an amount of $17,701.50.

LEGAL CONCLUSIONS

1. Respondent advanced as an affirmative defense an argument that parallels Government Code section 11506, subdivision (a)(6). Respondent argued that compliance with the regulations and law of the Board would result in a material violation of the regulations enacted by the Medical Board so as to adversely affect her substantive rights as a certified professional midwife (lay midwife). Respondent contended that Board lacks jurisdiction as she performed services through The Birthing Center as a certified professional midwife whose licensed activity is regulated by the Medical Board of California under regulations and statutes that do not pertain to registered nurses or nurse practitioners, who may engage in the provision of midwifery services. Hence, Respondent contended that Board lacks jurisdiction to discipline her by reason of her activities with the two subject patients.

Respondent advanced that the Board of Registered Nursing can only regulate a registered nurse or nurse practitioner when the Board issues a credential to the nurse to act as a Certified Nurse-Midwife (or CNM). Respondent declared that she is not a CNM. She asserted that there is a violation of her professional, substantive rights as a licensee of the Medical Board of California to be accused by the Board of Registered Nursing of unprofessional conduct in the practice of midwifery.

Respondent argued that discipline against her registered nurse licenses and certificates is unwarranted because the two patients, whose treatment is the subject of the Accusation, were poor candidates for midwifery services. She dealt with the patients during the early stages of her work through The Birthing Center and now she would not accept such personalities as her midwifery patients because of her enhanced experience over the past three years or so.

Respondent proclaimed that she cannot locate readily accessible medical doctors who are willing to actively engage the functions of supervising physician and surgeon of her midwife practices. Primarily, she contended, medical doctors are fearful of malpractice liability issues and so they uniformly decline to aid her midwifery work. But, Respondent contended that she has established relations with certain doctors, who perform services such as ultrasound on pregnant clients of The Birthing Center, and her midwifery facility is very close to Simi Valley Hospital so that she meets constructively the requirement of having supervising physicians and surgeons who are able to address complications of clients of The Birthing Center.

Respondent contended that she has developed a library of books, pamphlets, and articles regarding the administration of drugs so that she effectively has a set of protocols and procedures regarding the furnishing of controlled substances and dangerous drugs.

However, her arguments and contentions were neither persuasive nor compelling.

Moreover, Respondent offered no competent evidence in support of her primary affirmative defense that the Board lacks jurisdiction due to a supposed conflict that exists between the regulations of the Medical Board regarding the licensed activity of certified professional midwives and the Board of Registered Nursing, which regulates the licensed functions, responsibilities and duties of registered nurse practitioners, who may engage in providing services in the midwifery discipline. Respondent called no expert witness to support her view of the application of various California statutes and regulations the impact the midwifery practice.

Overview of Licensed Midwifery in California

2. Under the Licensed Midwifery Practice Act of 1993 (SB 350 (Stats. 1993, c. 1280)), lay midwives were granted the freedom to legally practice their trade or "calling," but such alternative health care providers are subject to continued restrictions, including a requirement that the lay midwife work under monitoring of a supervising physician and surgeon..

Before the 1993 Act, only registered nurses and physician assistants could, within the scope of their respective license practice acts, obtain enhanced licensure to function as a midwife. Lay persons, who engaged in midwifery functions, were subject to criminal prosecution. (See Bowland v. Municipal Court (1976) 18 Cal.3d 479.) By enacting the 1993 law, the Legislature expressed an intent that alternative health care would enable more California women to seize the choice of pursuing the cost-savings and supposed beneficial experience of tranquil and holistic child-birth settings offered by midwives.

California law regulates two classes of midwives: (i) the certified nurse-midwives (CNMs) and (ii) the certified professional midwives (also called lay (non-nurse) midwives). Certified Professional Midwives may gain their midwifery education through a variety of routes. They must have their midwifery skills and experiences evaluated through the North American Registry of Midwives (NARM) certification process and pass the NARM Written Examination and Skills Assessment. While Certified Nurse-Midwives (CNMs) are educated in both nursing and midwifery, after attending an educational program accredited by the American College of Nurse- Midwives Certification Council (ACC), the CNM candidate must pass the ACC examination and can be licensed.

The Legislature passed the California Licensed Midwifery Practice Act of 1993 (CLMPA), which provided midwives a means to become licensed to provide perinatal care to women and their infants and to attend births that primarily occur in birthing women's homes. The Practice Act succeeded in recognizing midwives as professionals who provide healthy women a safe alternative to physician care and hospital births.

The CLMPA established the scope of practice for licensed midwives and permits midwives to attend home deliveries, or deliveries in "birthing centers", if such midwives work under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics. The statute set out, at least, three key underpinning concepts for the regulation of midwives: (i) The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn; (ii) The practice of midwifery constitutes the furthering or undertaking by any licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician and surgeon immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version; and, (iii) the CLMPA established the physical presence of the supervising physician and surgeon was not required at all times that a midwife attended to patients.

Notwithstanding the foregoing, the 1993 law maintained both CNMs and lay midwives into subordinate and ancillary positions in the healthcare system relative to physicians and surgeons in matters that pertain to complications in the pregnancy or labor process and the furnishing of controlled substances, dangerous drugs and devices.

The Board's Regulatory Prerogative

3. Respondent is a licensed by the Medical Board of California as a certified professional nurse (lay midwife). Although Respondent McCulley is a registered nurse and nurse practitioner, she has not become a certified-nurse midwife (CNM). Respondent failed to provide any persuasive evidence that the Board of Registered Nursing is precluded from regulating her licensed activities and functions under her Registered Nurse License and Nurse Practitioner Certificate, despite her status as a lay midwife.

At the time of Respondent's unprofessional conduct, the California Licensed Midwifery Practice Act of 1993 had been in existence about a decade. But, under Business and Professions Code section 2746 et seq. (Code Chapter 6, Article 2.5), the Board of Registered Nursing has had legislation that empowers it to license and regulate nurse-midwifery practitioners since 1974. Over the span of thirty years, the Board has developed educational prerequisites and a specialized nurse-midwifery committee[14] to attend to developing and refining necessary standards related to matters that pertain to the safe and effective practice of midwifery. The Board has also devised a set of criteria for an individual nurse to show qualifications to obtain certification as a nurse-midwife. Such criteria is set out in California Code of Regulations, title 16, section 1460, which provides:

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14 Business and Professions Code section 2746.2. California Code of Regulations, title 16, section 1461 further defines the scope of the Nurse-Midwifery Committee.

(a) Initial certification.

(1) An applicant for certification to practice midwifery must meet the following conditions:

(A) Be licensed as a registered nurse under the Nursing Practice Act, Business and Professions Code, Section 2700, et seq., and

(B) Be a graduate of a Board approved program in nurse-midwifery.

(2) Equivalency. A registered nurse applicant not meeting the above requirements shall be eligible for certification, providing one of the following conditions exists:

(A) A graduate of a nurse-midwifery program not meeting Board of Registered Nursing standards who shows evidence satisfactory to the Board that deficiencies have been corrected in a Board approved nurse-midwifery program, or have been corrected through successful completion of specific courses which have been approved by the Board.

(B) Certification as a nurse-midwife by a national or state organization whose standards are satisfactory to the Board.

Respondent seems to possess the qualifications for licensure by the Board of Registered Nursing to practice nurse-midwifery. Yet, she has chosen only to be licensed as a lay midwife by the Medical Board of California.

The Board of Registered Nursing clearly defines the scope of a nurse-midwifery practice at California Code of Regulations, title 16, section 1463.[15]

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15 California Code of Regulations, title 16, section 1463, provides:

The scope of nurse-midwifery practice includes:

(a) Providing necessary supervision, care and advice in a variety of settings to women during the antepartal, intrapartal, postpartal, interconceptional periods, and family planning needs.

(b) Conducting deliveries on his or her own responsibility and caring for the newborn and the infant. This care includes preventive measures and the detection of abnormal conditions in mother and child.

(c) Obtaining physician assistance and consultation when indicated.

Business and Professions Code section 2746.4 provides that "nothing in [Article 2.5 (Nurse Midwives) of Chapter 6 (Nursing) of the Business and Professions Code] shall be construed to prevent the practice of midwifery by a person possessing a midwife's certificate issued by the Medical Board of California on the effective date of this article." (Emphasis added.) Article 2.5 was added to the law in 1974 by Stats 1974 ch. 1407. Hence the effective date of the article was on or about January 1, 1975. First, the Board's Accusation against Respondent does not, per se, seek to impose discipline against Respondent's license as a certified professional midwife (lay midwife), where that license was issued by the Medical Board of California. Rather the instant disciplinary action is against Respondent's unprofessional conduct, acts and omissions as a licensed registered nurse and nurse practitioner, while providing services in the midwifery practice. Second, in that Respondent was first licensed as a registered nurse (circa 1988) and later became a lay midwife (about 1991), and as Code section 2745.4 makes reference to the Board's statutory authority not impacting persons possessing a midwife's certificate as of January 1975, the Board of Registered Nursing may investigate, regulate and prosecute a licensed registered nurse practitioner, who engages in midwifery practice, despite her possessing a lay midwife certificate as issued by the Medical Board of California.

The Board of Registered Nursing has ample authority and jurisdiction to prosecute Accusation number 2006-186 that seeks discipline against the registered nurse license and certificates held by Respondent.

The Standard of Proof

4. In an administrative disciplinary action before the Board, Complainant must establish by "clear and convincing evidence to a reasonable certainty" that Respondent did the things alleged and that those allegations constituted cause for discipline as charged in the accusation. *(Eittinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal. App. 3d 853)

"'Clear and convincing' evidence means evidence of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth of the facts for which it is offered as proof. Such evidence requires a higher standard of proof than proof by a preponderance of the evidence." (BAJI No. 2.62 (8th ed. 1994).)

This means that the burden rests on Complainant to adduce proof that is clear, explicit, and unequivocal - so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. *(Mock vs. Michigan Millers*

(d) Providing emergency care until physician assistance can be obtained.

(e) Other practices and procedures may be included when the nurse-midwife and the supervising physician deem appropriate by using the standardized procedures as specified in Section 2725 of the Code.

Mutual Insurance Co (1992) 4 Cal.App.4th 306, 332; *Ettinger vs. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 855-858.)

Causes for Discipline

5. Business and Professions Code section 2761, subdivision (a)(1), provides that the Board may take disciplinary action against a licensed nurse for unprofessional conduct that includes incompetence or gross negligence in carrying out usual certified or licensed nursing functions.

California Code of Regulations, title 16, section 1442, sets forth:

> As used in Section 2761 of the [Business and Professions Code], 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

California Code of Regulations, title 16, section 1443, provides:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

California Code of Regulations, title 16, section 1443.5, establishes, the Standards of Competence Performance, which proclaims:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
>
> (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services

provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

Cause for discipline of Respondent's license and certificates exists under Business and Professions Code section 2761, subdivision (a)(1), as it interacts with California Code of Regulations, title 16, sections 1442 and 1443, by reason of the matters set out in Factual Findings 38 to 54, and 55 to 70, and 72 through 74.

6. Business and Professions Code section 2836.1, subdivision (a) sets out

Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation

or for which clinical competency has been established and maintained.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

Cause for discipline of Respondent's license and certificates exists under Business and Professions Code section 2761, subdivision (a)(1), as that provision interacts with Business and Professions Code section 2836.1, subdivisions (a), (b) and (c), by reason of the matters set out in Factual Findings 50 to 54, 61, 62, 70 to 74.

7. Business and Professions Code section 2836.1, subdivision (d) sets out:

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision.

Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

Cause for discipline of Respondent's license and certificates exists under Business and Professions Code section 2761, subdivision (a)(1), as that provision interacts with Business and Professions Code section 2836.1, subdivisions (d), by reason of the matters set out in Factual Findings 50 to 54, 57, 61, 62, 64-71, 73 and 74.

8. Business and Professions Code section 2746.5, subdivision (a), establishes

> (a) The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.

Cause for discipline of Respondent's license and certificates exists under Business and Professions Code section 2761, subdivision (a)(1), as that provision interacts with Business and Professions Code section 2746.5, subdivisions (a), by reason of the matters set out in Factual Findings 10 to 15, 17 to 28, 44-48, 55, 56, 59, 64-71, and 73-74.

9. Business and Professions Code section 2746.5, subdivision (b), sets out

> (b) As used in this chapter, the practice of nurse-midwifery constitutes the furthering or undertaking by any certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician immediately. The practice of nurse-midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

Cause for discipline of Respondent's license and certificates exists under Business and Professions Code section 2761, subdivision (a)(1), as that provision interacts with Business and Professions Code section 2746.5, subdivisions (b), by reason of the matters set out in Factual Findings 44-55, 57, 64-70, 72 and 74.

10. Business and Professions Code section 2762, subdivision (a), prescribes it is unprofessional conduct for a registered nurse to: ". . . [F]urnish or administer to another, any controlled substance as defined by Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022."

Cause for discipline of Respondent's license and certificates exists under Business and Professions Code section 2761, subdivision (a)(1), as that provision interacts with under Business and Professions Code section 2762, subdivision (a), by reason of the matters set out in Factual Findings 50 to 54, 58, 71 to 74.

Costs of Investigation and Prosecution

11. Complainant has requested that Respondent be ordered to pay the Board its costs of investigation and prosecution.

Business and Professions Code section 125.3, subdivision (a), in part provides: ". . . in any order issued in resolution of a disciplinary proceeding before any board within the department . . . [the board] may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

Although not made directly applicable to administrative adjudication by the Board through an appellate court decision, the California Supreme Court's reasoning on the obligation of a licensing agency to fairly and conscientiously impose costs in administrative adjudication in Zuckerman v. State Board of Chiropractic Examiners (2002) 29 Cal.4th 32, 45 - 46, is persuasive and should be considered in this matter. Scrutiny of certain factors, which pertain to the Board's exercise of discretion to analyze or examine factors that might mitigate or reduce costs of investigation and prosecution upon a licensee found to have engaged in unprofessional conduct, are set in Factual Finding 93.

12. Complainant claims to have incurred costs in an amount of $25,288.50 by reason of Factual Finding 92. However, based on Factual Findings 94 and 95, the reasonable cost of investigation and prosecution the Respondent is obligated to pay the Board is in an amount of $17,701.50.

13. The potential harm to the public is significant if Respondent persists in working as a midwife without the close monitoring of her patients by supervising physicians and surgeons.

Due to Respondent not retaining a medical doctor to help her craft patient specific protocols and procedures for Respondent's furnishing of dangerous drugs and controlled substances, the public's health, safety and welfare is at risk. Respondent testimony that she has a set of textbooks, guidelines, and reference material regarding the furnishing of drugs to patients indicates that she believes she can do it her way without following the laws and regulations governing the practice of nursing.

As the Administrative Law Judge pointed out in his Proposed Decision, complainant offered no evidence that the Board of Registered Nursing or the Medical Board of California has initiated or prosecuted to conclusion any prior disciplinary action against any professional license held by Respondent. The two cases arose within Respondent's first year of operating The Birthing Center, when she was inexperienced as a sole practitioner engaged in the private industry of midwifery practice. While the violations are quite serious in nature, they are limited to just two patients.

Until the Board can be assured that respondent is safe to resume practice, her license and certificates need to be placed on suspension until she successfully completes the necessary education and training. The Board would have imposed a more serious penalty in this matter if respondent's misconduct involved more than two patients.

Matters in mitigation and Respondent's background, as set out in Factual Findings 75 through 82 inclusive, were considered in making the Order herein.

ORDER

Registered Nurse License No. 429440, Nurse Practitioner Certificate No. 9578, Nurse Practitioner Furnishing Certificate No. 9578, and Public Health Nurse Certificate No. 49428 and issued to Respondent Marcia Kay McCulley, also known as Marcia Kay Hansen, are revoked. However, the revocation is stayed and the above license and certificates are placed on probation for a term of five (5) years under the following terms and conditions:

SEVERABILITY CLAUSE –
Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

SUSPENSION FROM PRACTICE -
Respondent's Registered Nursing License, Nurse Practitioner Certificate, Nurse Practitioner Furnishing Certificate and Public Health Nurse Certificate are hereby immediately suspended and Respondent is prohibited from practicing until she successfully completes a post-graduate level nursing course of study at a Board-approved nurse practitioner program. The course of study shall consist of at least 150 hours of classroom instruction (theory) and supervised clinical practice aimed at correcting the areas of deficient practice and knowledge. The course shall also include content on the legal scope of practice of registered nursing and nurse practitioner practice and the professional roles and responsibilities of professional nursing.

The course of study shall be at Respondent's expense and shall be in addition to the continuing education requirements for renewal of her license and certificates. Respondent shall submit within sixty days of the effective date of this decision the specifics of such a course of study including the name of the post-graduate Board-approved program, the name of the nursing program director, and a detailed description of her proposed course of study. The Board shall provide in writing to Respondent within 15 days of receipt of the

proposed course of study notice as to whether the course of study is acceptable or not. If the course of study is not acceptable, the Board shall provide written notice as to the deficiencies in the proposed course of study. Respondent may submit a new course of study if a previously submitted one is not accepted.

During the suspension period, if Respondent fails to either submit a proposed course of study that is acceptable to the Board within six months of the effective date of this decision or fails to successfully complete an acceptable course of study within one year from the effective date of this decision, it shall be deemed a violation of probation. Respondent shall provide in writing proof of successful completion of the course of study.

However, if Respondent has not complied with this condition of probation within one year of the effective date of this decision, upon submission of sufficient documentation of her good faith efforts to comply with this condition and documentation that she is in compliance with all other applicable conditions, the Board may, at its discretion, grant Respondent a one year extension to complete the course of the study.

The five-year probation term begins when the suspension of Respondent's license and certificates is terminated. Respondent shall comply with the following probation conditions 1, 2, 3, 4, 5, 11 and 12 during the period of suspension.

Respondent shall return her pocket license and certificates to the Board during the period of suspension, and the license and certificates shall be returned to Respondent upon termination of the suspension period. Respondent may render nursing services, under direct supervision of a licensed registered nurse or other appropriately licensed healthcare professional, during the period of suspension when those services are incidental to the acceptable course of study at the Board-approved nursing program.

(1) OBEY ALL LAWS - Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by the Respondent to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, Respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

(2) COMPLY WITH THE BOARD'S PROBATION PROGRAM - Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of the Respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension.

Upon successful completion of probation, Respondent's license shall be fully restored.

(3) REPORT IN PERSON - Respondent, during the period of probation, shall appear in person at interviews/meetings as directed by the Board or its designated representatives.

4) RESIDENCY, PRACTICE, OR LICENSURE OUTSIDE OF STATE Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if and when she resides outside of California. Respondent must provide written notice to the Board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

Respondent shall provide a list of all states and territories where she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the Board if she applies for or obtains a new nursing license during the term of probation.

(5) SUBMIT WRITTEN REPORTS - Respondent, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to Respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which he or she has a registered nurse license. And, Respondent shall mail a copy of this decision to the Medical Board of California, Lay Midwifery Practice Division.

(6) FUNCTION AS A REGISTERED NURSE - Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

For purposes of compliance with the section, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

If Respondent has not complied with this condition during the probationary term, and Respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of Respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

(7) EMPLOYMENT APPROVAL AND REPORTING REQUIREMENTS - Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

Respondent shall provide a copy of this decision to her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

In addition to the above, Respondent shall notify the Board in writing within seventy-two (72) hours after she obtains any nursing or other health care related employment. Respondent shall notify the Board in writing within seventy-two (72) hours after she is terminated or separated, regardless of cause, from any nursing, or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

(8) SUPERVISION - Respondent shall obtain prior approval from the Board regarding Respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours Respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with Respondent at least twice during each shift worked.

(d) Home Health Care - If Respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with Respondent as required by the Board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by the Respondent with or without Respondent present.

(9) EMPLOYMENT LIMITATIONS - Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict Respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If Respondent is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

(10) COST RECOVERY - Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of $17,701.50. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

If Respondent has not complied with this condition during the probationary term, and Respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of Respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation will apply.

(11) VIOLATION OF PROBATION - If Respondent violates the conditions of her probation, the Board after giving Respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed revocations of Respondent's license and certificates.

If during the period of probation, an accusation or petition to revoke probation has been filed against Respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against Respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

(12) LICENSE SURRENDER - During Respondent's term of probation, if she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, Respondent may surrender her license to the Board. The Board reserves the right to evaluate Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, Respondent will no longer be subject to the conditions of probation.

Surrender of Respondent's license shall be considered a disciplinary action and shall become a part of Respondent's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

1. Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

2. One year for a license surrendered for a mental or physical illness.

This Decision shall become effective on August 2, 2007.

IT IS SO ORDERED this 3rd day of July 2007.

LaFrancine Tate

LAFRANCINE TATE
BOARD OF REGISTERED NURSING
STATE OF CALIFORNIA

Exhibit B

Interim Suspension Order

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition for Interim *Suspension Order Against:*	**OAH No. L2007010454**
MARCIA KAY MCCULLEY **a.k.a. MARCIA KAY HANSEN** **912 Estates Drive** **Newbury Park, California 91320**	
Registered Nurse License No. 429440 **Nurse Practitioner Certificate No. 9578** **Nurse Practitioner Furnisher Certificate No. 9578** **Public Health Nurse Certificate No. 49428,**	
Respondent.	

ORDER GRANTING INTERIM SUSPENSION

On January 19, 2007, at Los Angeles, California, the Petition of Ruth Ann Terry, MPH, RN (Petitioner), Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs, for issuance, on an ex parte basis, of an Interim Order of Suspension, pursuant to Business and Professions Code section 494, came on for hearing before Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings.

Anne Hunter, Deputy Attorney General, represented Petitioner. Marcia Kay McCulley, a.k.a. Marcia Kay Hansen (Respondent), was present and represented herself.

The Administrative Law Judge read and considered the ex parte petition and the declarations and points and authorities filed in support thereof, and heard and considered the oral argument made by the parties at the hearing. The matter was submitted on January 19, 2007.

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FACTUAL FINDINGS

1. Petitioner filed the Ex Parte Petition for Interim Suspension Order (Petition) while acting in her official capacity as the Executive Officer of the Board.

2(a). On August 31, 1988, the Board issued Registered Nurse License No. 429440 to Respondent.

2(b). On September 4, 1992, the Board issued Public Health Nurse Certificate No. 49428 to Respondent.

2(c). On December 19, 1997, the Board issued Nurse Practitioner Certificate No. 9578 to Respondent.

2(d). On July 31, 1998, the Board issued Nurse Practitioner Furnisher Certificate No. 9578 to Respondent.

2(e). Respondent's license and certificates listed above were in full force and effect at all relevant times and will expire on March 31, 2008, unless renewed.

3. The Board has never issued a Nurse Midwife Certificate to Respondent.

4. On August 21, 2001, the Medical Board of California issued Respondent a license to practice lay midwifery.

5. Prior to 2003, Respondent began operating a birthing center named "The Whole Woman, Inc." (birthing center), where she provided midwifery services. The birthing center was located across the street from Simi Valley Hospital (SVH) in Simi Valley, California.

6. On April 17, 2006, Petitioner filed against Respondent Accusation No. 2006-186 (prior Accusation), alleging unprofessional conduct, gross negligence, improper furnishing of dangerous drugs/controlled substances, and exceeding the scope of practice, all pertaining to the care of two patients in 2003. The hearing on the prior Accusation took place in October of 2006. A Proposed Decision was issued on December 11, 2006, proposing that Respondent be placed on five years probation under specified terms and conditions. The Board has not yet acted on the Proposed Decision.[1]

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[1] The Proposed Decision, submitted as supporting evidence for the Petition, established only the facts set forth in this Factual Finding. The Administrative Law Judge did not consider the Proposed Decision as direct evidence to establish any other facts, since it has not yet been adopted by the Board and lacks finality.

7. The instant Petition involves Respondent's care of eleven patients at Respondent's birthing center in 2004, 2005 and 2006. However, only seven of the eleven cases have been fully investigated by the Board, and the medical records regarding those seven patients were submitted with the Petition. Additionally, only the care of those seven patients (Patients Nos. 32-15-14, 32-64-12, 09-62-22, 06-47-70, 33-27-24, 33-87-41 and 33-96-84) were addressed in the Memorandum of Points and Authorities filed concurrently with the Petition.[2] Consequently, only the care of those seven patients is considered to be at issue in the instant Petition.

8(a). Erin Dunn, R.N.P., C.N.M, M.S.N. (Ms. Dunn), an expert in the practice of nursing and midwifery, reviewed the records pertaining to Respondent's care of the seven patients. Ms. Dunn was unable to render a definitive opinion regarding Respondent's care one of the seven patients (Patient No. 09-62-22) because she was not provided a copy of Respondent's records pertaining to that patient. Consequently, Respondent's care of the seventh patient was not considered in determining whether to issue the interim suspension order.

8(b). Additionally, Ms. Dunn, a certified nurse midwife, evaluated Respondent's midwifery care and opined regarding the quality of that care. Since Respondent was licensed as a lay midwife by the Medical Board, not as a certified nurse midwife by the Board, any allegations pertaining solely to the quality of Respondent's midwifery care was not considered in determining whether to issue the interim suspension order.[3] While Respondent's alleged negligence in performing specific midwife services (which do not also involve nursing functions) may be a violation of the Medical Practice Act, the Medical Board is the agency charged with making the determination of whether its licensees have committed any such violations (i.e. whether they have deviated from the applicable standard of care). However, any care at Respondent's birthing center which was rendered, in whole or in part, by virtue of her nursing license and/or certificates was considered in determining whether Respondent violated the Nursing Practice Act and, thus,

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[2] The patients' medical record/patient numbers are used herein in order to protect the patients' privacy.

[3] It is significant that the code section under which the Petition alleges Respondent's violations, Business and Professions Code section 2761, subdivision (a)(1), authorizes disciplinary action for "[i]ncompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

whether an interim suspension order should issue.[4] In this case, Respondent used her nurse practitioner furnisher certificate to furnish medications to her patients. Consequently, any alleged violations pertaining to her provision of medication to her patients come within the province of the Board and were, therefore, considered in determining whether to issue the interim suspension order.

Patient No. 32-15-14:

9(a). Petitioner proved, by a preponderance of the evidence, the allegations in paragraph 17 of the Petition, pertaining to Patient No. 32-15-14, which are repeated verbatim below and are incorporated as factual findings herein:

> On June 22, 2004, Respondent transferred a 24 year old patient [patient number 32-15-14] to Simi Valley Hospital from her birthing center. Respondent's prenatal notes indicate the patient was 38 weeks pregnant, was a Group Beta Streptococcus (GBS) carrier and had been treated for a urinary tract infection on June 19, 2004. Respondent's notes further indicate the patient arrived at the birthing center on June 22, 2004, at 0100 hours. She received Clindamycin 900 mg IV at 0330 for her GBS status. Labor progressed appropriately until 1600 hours when the patient's cervix had not changed from 9 cm since 10:00 a.m. Respondent gave the patient Stadol and Toradol for pain and did not transfer her to the hospital for another 3 hours. Respondent faxed the hospital the patient's records at 1915 hours indicating the reason for the transfer was pain. No mention was made of the patient's failure to progress in labor. Respondent did not accompany the patient to the hospital and failed to give a report to either the supervising or on-call OB/GYN physician. The hospital delivered the baby by C-section because of the patient's failure to progress in labor.

9(b). [Regarding Respondent's care of patient no. 32-15-14,] Ms. Dunn concluded, inter alia, that Respondent "was grossly negligent in furnishing a dangerous drug (Toradol) and a Schedule IV controlled substance (Stadol) to the patient without being supervised by a licensed physician and surgeon, without having a supervising physician available by telephone when she was examining the patient, and without developing, having or complying with standardized protocols or

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[4] Respondent maintained that the Medical Board alone governs her midwifery practice, and that, while there is some crossover between midwifery and nursing, that does not mean that such crossover actions are governed by the Board. This argument was not persuasive. The Board has the jurisdiction to regulate any activities by its licensees while carrying out their nursing functions. The fact that their nursing functions may overlap with functions carried out under another agency's licensure does not deprive the Board of its disciplinary oversight.

procedures approved by the treating or supervising physician." (Petition, para. 19; Declaration of Ms. Dunn, para. 4.)

9(c). At the administrative hearing, Respondent stated that she was "willing to admit to prescribing medications outside the scope of practice." She noted that she does not have an individual physician to sign her protocols, but emphasized that they are "standardized published protocols." She maintained that she only uses medications with which she has had experience for many years as a nurse, and which "are known to be safe when used conservatively."

9(d). Petitioner established that Respondent acts set forth above constituted a violation of Business and Professions Code sections 2761, subdivision (a)(1), 2762, subdivision (a), and 2836.1, and California Code of Regulations, title 16, section 1442.

Patient No. 32-64-12:

10(a). Petitioner proved, by a preponderance of the evidence, virtually all of the factual allegations in paragraph 19 of the Petition, pertaining to Patient No. 32-64-12, which are repeated verbatim below and are incorporated as factual findings herein:

> On November 27, 2004, respondent sent a . . . maternity patient from her birthing center to SVH.[5] Respondent's records indicate the patient began labor on November 25, 2004, that at 0545 hours on November 26, 2004, respondent artificially ruptured the patient's membranes, when the patient was dilated to 8 cm, and that in the next 17 hours the patient dilated only one more centimeter. The records also indicate that respondent gave the patient Toradol and Stadol intravenously. Respondent's transfer summary record indicates the patient was dilated to 9 cm, that the patient had been in labor for 29 hours with ruptured membranes for 18 hours, and that the reason for the transfer was failure of descent and arrested second stage labor.

10(b). Ms. Dunn concluded that "respondent was negligent when she failed to further evaluate the patient or consult with a supervising physician and allowed the patient to labor for seventeen hours while progressing only 1 cm. in dilation." Ms. Dunn also concluded that, "respondent was negligent when she allowed the patient to push actively before she was dilated to 10 cm." Ms. Dunn further opined that "respondent's conduct was unprofessional in sending the patient to SVH without verbalizing a complete and detailed report to the accepting physician." (Declaration of Ms. Dunn, para. 6.)

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[5] Paragraph 19 of the Petition alleges that the patient was 31 years old, but the patient's medical records indicate that she was 32 years old.

10(c). The negligence and unprofessional conduct found by Ms. Dunn pertained solely to the quality of Respondent's midwifery care and not to care rendered by virtue of her nursing license and/or certificates. Consequently, the facts set forth in this Factual Finding, together with Ms. Dunn's conclusions, do not establish any violation of the Nursing Practice Act and are not considered as a basis for the issuance of an interim suspension order. (See Factual Finding 8(b), above.)

Patient No. 06-47-70:

11(a). Petitioner proved, by a preponderance of the evidence, the factual allegations in paragraph 23 of the Petition, pertaining to Patient No. 06-47-70, which are repeated verbatim below and are incorporated as factual findings herein:

> On February 19, 2005, respondent sent a twenty-five year old VBAC (vaginal birth after [Cesarean]) patient to SVH from her birthing center. According to respondent's records, the patient arrived at the birthing center on February 18, 2005 and was 3 cm dilated. The patient's membranes ruptured on February 19, 2005 at 0200 hours. Her dilation progressed to 7 [cm] at 0245 hours, to 8 [to] 9 [cm] at 0400 hours and to 9 [cm] at 0600 hours. Her dilation then stopped progressing and she was transferred to SVH at 1500 on February 19, 2005. The hospital delivered the baby by [Cesarean] section on February 19th.

11(b). Ms. Dunn concluded:

> [R]espondent was grossly negligent when she knowingly attempted [VBAC] delivery in her birthing center without a supervising physician or a physician back up. Both the American College of Nurse Midwives and at least one reported national study require or recommend that midwives inform patients about the risks of VBAC and have patients sign a consent form before attempting VBAC, heighten fetal surveillance for VBAC patients, have well-established and on-going communication between the midwife and the supervising physician, and induce labor only in a hospital setting. . . . (Declaration of Ms. Dunn, para. 10.)

11(c). The gross negligence found by Ms. Dunn pertained solely to the quality of Respondent's midwifery care and not to care rendered by virtue of her nursing license and/or certificates. Consequently, the facts set forth in this Factual Finding, together with Ms. Dunn's conclusions, do not establish any violation of the Nursing Practice Act and are not considered as a basis for the issuance of an interim suspension order. (See Factual Finding 8(b), above.)

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Patient No. 33-27-24:

12(a). Petitioner proved, by a preponderance of the evidence, the factual allegations in paragraph 25 of the Petition, pertaining to Patient No. 33-27-24, which are repeated verbatim below and are incorporated as factual findings herein:

> On June 15, 2005, respondent sent a thirty-one year old VBAC patient to SVH from her birthing center. Respondent's transfer summary indicates the patient was in labor 20 hours with her membranes artificially ruptured at 2115 hours. The summary also indicates respondent gave the patient Stadol at 0500, 1100 and 1350 hours. The records further indicate that the patient failed to dilate further than 9 cm. At the hospital the patient was able to push the fetus down to a +2 station, but the fetal heart rate slowed and showed increasingly variable decelerations. In addition, the patient was exhausted. The patient was [sic] then consented to a vacuum assist and after three contractions, a viable baby boy was delivered.

12(b). Ms. Dunn opined that Respondent "was grossly negligent when she knowingly attempted a [VBAC] delivery in her birthing center without a supervising physician or physician back up." (Declaration of Ms. Dunn, para. 12.) She also noted that Respondent was "practicing outside of both her midwifery license and her nurse practitioner license due to the fact that she has no supervising physician." (Exhibit 1.A.8.)

12(c). The laws governing lay midwives (similar to the laws governing certified nurse midwifes) require the midwife to be supervised by a physician and surgeon. (Bus. & Prof. Code §§ 2507, subd. (a), and 2746.5, subd. (a).) Respondent admitted that she does not have a supervising physician. Neither her nursing license nor her certificates, including her Nurse Practitioner and Nurse Practitioner Furnisher certificates, authorize her to attend the cases of childbirth without a supervising physician. As such, Respondent is practicing outside the scope of her nursing license and certificates, in violation of Business and Professions Code section 2725 and 2726.

12(d). Petitioner established that Respondent acts set forth above constituted a violation of Business and Professions Code sections 2761, subdivision (a)(1), and subdivision (a), 2725 and 2726.

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Patient No. 33-87-41:

13(a). Petitioner proved, by a preponderance of the evidence, the factual allegations in paragraphs 27 and 28 of the Petition, pertaining to Patient No. 33-87-41, which are repeated verbatim below and are incorporated as factual findings herein:

> On December 21, 2005, respondent sent a 37 year old patient who was 39 and 3/7 weeks pregnant to [SVH] from her birthing center. Respondent's prenatal notes indicate the patient had had 4 ultrasounds all documenting a marginal placenta previa. The chart does not mention discussing the marginal previa with the patient, delivery options, risk of bleeding, or risk to mother or fetus. The chart does not mention a supervising physician or physician consult. The chart indicates the patient was a known GBS carrier and that she was given oral amoxicillin and ampicillin for 3 weeks before delivery. Respondent's labor notes indicate the patient presented at the birthing center after a "gush" of approximately 1 cup of bleeding, 4 cm dilated, 50% effaced, and -1station. Respondent allowed the patient to labor for approximately 4 hours before sending her to the hospital. Respondent's transfer notes indicate the patient lost 800 cc of blood, had failed to progress in labor and had a low lying placenta. Catherine Kim, M.D., performed an emergency C-section at the hospital due to a bleeding [placenta] previa.
>
> [In a post-operative note, on] December 21, 2006, Dr. Kim noted that the placenta [had] covered half of the patient's cervix.

13(b). Ms. Dunn opined:

> [R]espondent was grossly negligent in her treatment of [Patient No. 33-87-41]. Respondent's prenatal records show respondent knew the patient was a GBS carrier and knew that the patient had 4 ultrasounds documenting a marginal placenta previa. Marginal previa is the "encroachment of the placenta to the margin of the cervical os,"[6] associated with life threatening hemorrhage before or during labor. The implantation site of the placenta is the origin of the bleeding. If labor progresses and dilation furthers, the placental edge becomes detached. Vaginal delivery may be possible with marginal previa but it must be done in a setting where an emergency [C]esarean can be performed. Cesarean delivery is the preferred method for patients with any degree of previa. The patient should be counseled during her pregnancy regarding the risks and delivery options. Patients with any

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[6] The source of this quote was not listed in Ms. Dunn's Declaration.

type of previa are considered high risk. [R]espondent's treatment of this patient [was] grossly negligent in that she failed to consult with a physician about the patient's high-risk, marginal previa condition and because she should have referred the patient to the hospital immediately when the patient arrived at the birthing center in labor and bleeding. In addition, . . . respondent [was] negligent in her treatment of this GBS-positive patient with oral antibiotics for weeks prior to delivery. The standard of care is to give [IV] penicillin at the onset of labor and every four hours until delivery. (Declaration of Ms. Dunn, para. 14.)

13(c). The gross negligence and negligence found by Ms. Dunn pertained solely to the quality of Respondent's midwifery care and not to care rendered by virtue of her nursing license and/or certificates. Consequently, the facts set forth in this Factual Finding, together with Ms. Dunn's conclusions, do not establish any violation of the Nursing Practice Act and are not considered as a basis for the issuance of an interim suspension order. (See Factual Finding 8(b), above.)

Patient No. 33-96-84:

14(a). Petitioner proved, by a preponderance of the evidence, the following factual allegations in paragraph 32 of the Petition, pertaining to Patient No. 33-87-41, which are incorporated as factual findings herein:[7]

On January 19, 2006, respondent delivered the 6 pound 3 ounce male infant of a 16 year old patient who was approximately 36 weeks pregnant. Labor and delivery occurred at respondent's birthing center . . . Respondent failed to deliver the placenta and kept the patient at her center for 8 hours after the delivery of the baby. She then sent the patient . . . to [SVH]'s emergency room [along with the patient's prenatal records]. The placenta had to be removed surgically and the patient needed and was given . . . blood transfusions.

14(b). Ms. Dunn opined:

[R]espondent was grossly negligent when she waited 8 hours before transferring the patient to the hospital to deliver the retained placenta. Respondent's records indicate the infant was delivered at 0230 hours; the hospital records indicate the patient was admitted a 1100 hours the same day. Delay in removing the placenta can lead to significant blood loss and subsequent anemia requiring blood transfusions. It can lead to infection for the mother. The delay caused the patient to be anemic when she arrived at the hospital and to require a three-unit blood

[7] Those allegations not proven have been eliminated from the quotation.

transfusion. In addition, respondent was negligent in failing to accompanying [sic] the patient to the hospital and in not giving a full and detailed report to the attending physician. Finally, as with the other complaints against respondent that I have reviewed, she was, in my opinion, grossly negligent in caring for this patient without a supervising or back up physician. . . . (Declaraion of Ms. Dunn, para. 16.)

14(c). Petitioner established that Respondent's acts set forth above constituted a violation of Business and Professions Code sections 2761, subdivision (a)(1), and subdivision (a), 2725 and 2726. (See also, Factual Finding 12(c).)

LEGAL CONCLUSIONS

1. Respondent has engaged in acts or omissions constituting a violation of the Nursing Practice Act.

2. Permitting Respondent to continue to engage in the licensed activity would endanger the public health safety and/or welfare.

3. It appears from the petition and supporting documents that serious injury would result to the public if the below Order is not issued on an ex parte basis.

4. Respondent's violations were committed knowingly, and at least one violation involved the furnishing of a dangerous drug and a controlled substance without the required supervision. It is unlikely that protection of the public could be accomplished short of suspension of Respondent's license and certificates.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

1. The Ex Parte Petition for Interim Order of Suspension is granted.

2. Registered Nurse License No. 429440, issued to Respondent, Marcia Kay McCulley, a.k.a. Marcia Kay Hansen, and all licensing rights appurtenant thereto, is hereby suspended pending a full administrative determination of Respondent's fitness to practice registered nursing, unless otherwise ordered following the noticed hearing on the Petition for Interim Order of Suspension.

3. Public Health Nurse Certificate No. 49428, issued to Respondent, Marcia Kay McCulley, a.k.a. Marcia Kay Hansen, and all licensing rights appurtenant thereto, is hereby suspended pending a full administrative determination of Respondent's fitness to practice as a public health nurse, unless otherwise ordered following the noticed hearing on the Petition for Interim Order of Suspension.

4. Nurse Practitioner Certificate No. 9578, issued to Respondent, Marcia Kay McCulley, a.k.a. Marcia Kay Hansen, and all licensing rights appurtenant thereto, is hereby suspended pending a full administrative determination of Respondent's fitness to practice as a nurse practitioner, unless otherwise ordered following the noticed hearing on the Petition for Interim Order of Suspension.

5. Nurse Practitioner Furnisher Certificate No. 9578, issued to Respondent, Marcia Kay McCulley, a.k.a. Marcia Kay Hansen, and all licensing rights appurtenant thereto, is hereby suspended pending a full administrative determination of Respondent's fitness to practice as a nurse practitioner certified to furnish or prescribe dangerous drugs or controlled substances, unless otherwise ordered following the noticed hearing on the Petition for Interim Order of Suspension.

6. Respondent shall not:

a. Practice or attempt to practice any aspect of nursing in the State of California until the final decision of the Board following an administrative hearing;

b. Be present in any location which is maintained for the purpose of nursing, or at which nursing is practiced, for any purpose, except as a patient;

c. Advertise, by any means, or hold herself out as practicing or available to practice nursing.

7. Respondent shall, no later than 12:00 p.m. on January 29, 2007, deliver to the Board, or its agent, for safekeeping pending a final administrative order of the Board in this matter, all indicia of her licensure as a registered nurse, and her certification as a public health nurse, as a nurse practitioner and as a nurse practitioner furnisher, including, but not limited to, her wall certificate(s) and wallet card(s) issued by the Board.

8. A noticed hearing on the Petition for Interim Order of Suspension shall be held on February 13, 2007 at 1:30 p.m., at the Office of Administrative Hearings, located at 320 West Fourth Street, Suite 630, Los Angeles, California. Petitioner shall give notice of the hearing in compliance with the provisions of Business and Professions Code section 494(c).

9. Any further documents offered in support of the Petition for Interim Suspension Order, and any documents offered in opposition to the Petition for Interim Suspension Order shall be served and filed no later than February 9, 2007.

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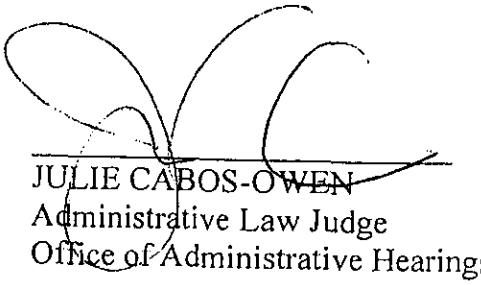
DATED: January 23, 2007



JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings

PROOF OF SERVICE

I, Veronica Ramirez, declare as follows: I am over 18 years of age and am not a party to this action. My place of employment and business address is:

The Office of Administrative Hearings
320 West 4th Street, Suite 630
Los Angeles, CA 90013

On January 25, 2007, I served a copy of the following document(s) in the action entitled below:

ORDER GRANTING INTERIM SUSPENSION-OAH NO. L2007010454

to each of the person(s) named below at the addresses listed after each name by the following method(s):

Marcia Kay McCulley, a.k.a. Marcia Kay Hansen
912 Estates Drive
Newbury Park, CA 91320
(Via overnight delivery)

Anne Hunter, Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
(Via overnight delivery)

☒ **Overnight delivery.** I enclosed the above-described document(s) in a sealed envelope or package addressed to the person(s) at the address(es) listed above, and placed the envelope or package with overnight delivery fees paid at an office or a location regularly utilized for collection and overnight delivery by an authorized overnight delivery courier.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and this declaration was executed at **Los Angeles, California** on January 25, 2007:

VR

Veronica Ramirez

Exhibit C

Accusation No. 2007-249

EDMUND G. BROWN JR., Attorney General
of the State of California
MARC D. GREENBAUM
Supervising Deputy Attorney General
ANNE HUNTER, State Bar No. 136982
Deputy Attorney General
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300 So. Spring Street, Suite 1702
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Telephone: (213) 897-2114
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MARCIA KAY MCCULLEY 2950 N. Sycamore Dr. #201 Simi Valley CA, 93065 Registered Nurse License No. 429440 Nurse Practitioner Certificate No. 9578 Nurse Practitioner Furnishing Certificate No. 9578 Public Health Nurse Certificate No. 49428 Respondent.	Case No. 2007-249 OAH No. **ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant Ruth Ann Terry, M.P.H., R.N., Executive Officer brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1988, the Board of Registered Nursing issued Registered Nurse License No. 429440 to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen. The Registered Nurse License was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

3. On or about December 19, 1997, the Board of Registered Nursing issued Nurse Practitioner Certificate No. 9578 to Respondent. The Nurse Practitioner Certificate was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

4. On or about July 31, 1998, the Board of Registered Nursing issued Nurse Practitioner Furnisher Certificate 9578 to Respondent. The Nurse Practitioner Furnisher Registration was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

5. On or about September 4, 1992, the Board of Registered Nursing issued Public Health Nurse Certificate No. 49428 to Respondent. The Public Health Nurse License was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

JURISDICTION

6. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

7. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

8. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), of the Code, the Board may renew an expired license at any time within eight years after the expiration.

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9. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

". . . .

"(3) The use of advertising relating to nursing which violates Section 17500.

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

". . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

". . . .

"(j) Holding oneself out to the public or to any practitioner of the healing arts as a 'nurse practitioner' or as meeting the standards established by the board for a nurse practitioner unless meeting the standards established by the board pursuant to Article 8 (commencing with Section 2834) or holding oneself out to the public as being certified by the board as a nurse anesthetist, nurse midwife, clinical nurse specialist, or public health nurse unless the person is at the time so certified by the board."

10. Code Section 17500 provides in pertinent part:

"It is unlawful for any person, firm, corporation or association, or any employee thereof with intent directly or indirectly to . . . to perform services, professional or otherwise, or anything of any nature whatsoever or to induce the public to enter into any obligation relating

thereto, to make or disseminate or cause to be made or disseminated before the public in this state, or to make or disseminate or cause to be made or disseminated from this state before the public in any state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatever, including over the Internet, any statement, concerning . . . those services, professional or otherwise, or concerning any circumstance or matter of fact connected with the proposed performance . . ., which is untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading. . . ."

11. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

12. Section 2836.1 provides in pertinent part that a nurse practitioner may furnish or order drugs or devices when all of the following apply:

"(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

"(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

"(c)(1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

"(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

"(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

"(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

"(f)(1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

"(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order."

13. Section 2725 of the Code states:

"(a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

"(b) The practice of nursing within the meaning of this chapter [the Nursing Practice Act] means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, ...

"(c) 'Standardized procedures,' as used in this section, means either of the following:

"(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

"(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

"The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of

Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing.

"(d) Nothing in this section shall be construed to require approval of standardized procedures by the Division of Licensing of the Medical Board of California, or by the Board of Registered Nursing."

14. Section 2726 of the Code states that "[e]xcept as otherwise provided herein, this chapter [the Nursing Practice Act] confers no authority to practice medicine or surgery."

15. Section 2795 of the Code states:

"Except as provided in this chapter [the Nursing Practice Act] , it is unlawful for any person to do any of the following:

"(a) To practice or to offer to practice nursing in this state unless the person holds a license in an active status.

"(b) To use any title, sign, card, or device to indicate that he or she is qualified to practice or is practicing nursing, unless the person has been duly licensed or certified under this chapter [the Nursing Practice Act]."

16. Section 2732 of the Code states:

"No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter [the Nursing Practice Act] except as otherwise provided in this act. . . ."

17. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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18. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

19. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

20. Code section 494, subdivision (i), provides in pertinent part:

"Failure to comply with an interim order issued pursuant to subdivision (a) or (b) shall constitute a separate cause for disciplinary action against any licentiate, and may be heard at, and as a part of, the noticed hearing provided for in subdivision (f). Allegations of noncompliance with the interim order may be filed at any time prior to the rendering of a decision on the accusation. Violation of the interim order is established upon proof that the licentiate was on notice of the interim order and its terms, and that the order was in effect at the time of the violation. The finding of a violation of an interim order made at the hearing on the accusation shall be reviewed as a part of any review of a final decision of the agency."

21. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

22. **CONTROLLED SUBSTANCES**

A. "Ambien," a generic name for zolpidem tartrate, a nonbarbiturate hypnotic, is designated as a Schedule IV controlled substance by Health and Safety Code section 11057, subdivision (d)(32), and is categorized as a dangerous drug pursuant to Business & Safety Code section 4022.

B. "Apap/Hydrocodone Bitartrate" is a Schedule II narcotic substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug pursuant to Business and Professions Code section 4022.

C. "Homatropine/Hydrocodone" is a Schedule V substance pursuant to Health and Safety Code section 11058, subdivision (c)(2), and a dangerous drug pursuant to Business and Professions Code section 4022.

D. "Hydromet," a brand name for Homatropine/Hydrocodone, is a Schedule V substance pursuant to Health and Safety Code section 11058, subdivision (c)(2), and a dangerous drug pursuant to Business and Professions Code section 4022.

E. "Stadol," a brand name for Butorphanol, is a Schedule IV controlled

substance pursuant to Health and Safety Code section 11057, subdivision (c)(3), and a dangerous drug pursuant to Business and Professions Code section 4022.

F. "Testosterone Cypionate," an anabolic steroid, is a Schedule III substance pursuant to Health & Safety Code section 11056, subdivision (f)(30), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. **DANGEROUS DRUGS**

A. "Ampicillin" is an antibiotic used to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. It is a dangerous drug pursuant to Business and Professions Code section 4022.

B. "Amoxicillin" is an antibiotic used to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. It is a dangerous drug pursuant to Business and Professions Code section 4022.

C. "Clindamycin" is used primarily to treat infections caused by susceptible anaerobic bacteria. It is a dangerous drug pursuant to Business and Professions Code section 4022.

D. "Levoxyl," a brand name for Levothyroxine, is a synthetic form of thyroxine (thyroid hormone). It is a hormone replacement usually given to patients with thyroid problems, such as hypothyroidism. It is a dangerous drug pursuant to Business and Professions Code section 4022.

E. "Prochlorperazine" is a highly potent neuroleptic, commonly used to treat nausea. It is a dangerous drug pursuant to Business and Professions Code section 4022.

F. "Rhogam," a trade name for RHO(D) Immune Globulin, is used to prevent maternal sensitization to Rh D antigens on the surface of blood cells in a fetus. It is a dangerous drug pursuant to Business and Professions Code section 4022.

G. "Synthroid," a brand name for Levothyroxine, is a synthetic form of thyroxine (thyroid hormone). It is a hormone replacement usually given to patients with thyroid problems, such as hypothyroidism. It is a dangerous drug pursuant to Business and Professions Code section 4022.

H. "Toradol," a trade name for Ketorolac or ketorolac tromethamine, is a non-steroidal anti-inflammatory drug (NSAID) in the family of propionic acids, often used as an analgesic, antipyretic (fever reducer), and anti-inflammatory. It is a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

24. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for unprofessional conduct, in that, respondent committed acts of incompetence and/or gross negligence, within the meaning of California Code of Regulations, title 16, sections 1442, 1443 and 1443.5. The circumstances are as follows:

Patient No. 32-15-14[1]

25. On June 22, 2004, respondent transferred a 24 year old maternity patient to Simi Valley Hospital [SVH] from her birthing center, The Whole Woman, Inc., located at 2950 North Sycamore Drive in Simi Valley, California. Respondent's prenatal notes indicate the patient was 38 weeks pregnant, was a Group Beta Streptococcus [GBS] carrier and had been treated for a urinary tract infection on June 19, 2004. Respondent's notes further indicate the patient arrived at the birthing center on June 22, 2004, at 0100 hours. Respondent administered Clindamycin 900 mg IV at 0330 for the patient's GBS status. Labor progressed appropriately until 1600 hours when the patient's cervix had not changed from 9 cm since 10:00 a.m. Respondent gave the patient Stadol and Toradol for pain and did not transfer her to the hospital for another 3 hours. Respondent was not being supervised by a licensed physician and furnished the two dangerous drugs and one controlled substance to the patient without developing or having standardized protocols and procedures pre-approved by a supervising physician. Respondent faxed the hospital the patient's records at 1915 hours indicating the reason for the transfer was pain. No mention was made of the patient's failure to progress in labor. Respondent did not accompany the patient to the hospital and failed to give a report to either the

1. Patient numbers are those assigned to the patients after admission to SVH.

supervising or on-call OB/GYN physician. The hospital delivered the baby by C-Section because of the patient's failure to progress in labor.

Patient No. 32-64-12

26. On November 27, 2004, respondent transferred a 31 year old, primiparous (first pregnancy) patient to Simi Valley Hospital from her birthing center. Respondent's prenatal notes indicate the patient was 38 and 6/7 weeks pregnant and 5-6 cm dilated when she presented to the center at 0015 hours on November 26, 2004. Respondent artificially ruptured the patient's membranes. Respondent's records indicate she noted light meconium, a sign of fetal stress, in the fluid at 0600 hours, and that the patient remained 8 cm dilated from 0545 until 1530 hours. By 1730 the patient had progressed to 9cm dilated but was still at 9cm at 2315 hours.. Respondent gave the patient Stadol at 0930 and 1630 hours; she gave the patient Toradol at 1230 and 1730 hours. Respondent was not being supervised by a licensed physician and did not have standardized procedures and protocols that she had developed with and had pre-approved by a licensed physician when she furnished the medications. At 0040 hours on November 27, 2004, the patient, unaccompanied by respondent, arrived at SVH with a copy of her records. The transfer notes stated the patient was transferred during second stage labor due to arrested second stage labor and failure of the fetus to descend. Respondent failed to accompany the patient to SVH and to give a verbal report of her labor progress to the on-call physician at SVH.

Patient No. 06-47-70

27. Respondent's prenatal records of this patient indicate that on or about January 31, 2005, respondent prescribed Synthroid for the patient, after diagnosing her with hypothyroidism. Respondent had no standardized protocols and procedures developed with and pre-approved by a licensed physician at the time she prescribed the Synthroid. On February 19, 2005, respondent sent this twenty-five year old VBAC (vaginal birth after cesarian) patient to SVH from her birthing center. According to respondent's records, the patient was 3 cm dilated when she arrived at the birthing center at 1800 hours on February 18, 2005. The patient's membranes ruptured on February 19, 2005, at 0200 hours. Respondent administered Stadol to the patient at 0100 hours, 0230 hours, and 0500 hours on February 19, 2005. Respondent

administered Toradol to the patient at 0300 hours on February 19, 2005. Respondent was not supervised by a licensed physician and had no standardized protocols and procedures for medicating patients pre-approved by a licensed physician at the time she furnished the controlled substance Stadol and the dangerous drug Toradol to the patient. The patient's dilation progressed to 7 cm at 0245 hours, to 8-9 cm at 0400 hours and to 9 cm at 0600 hours. The patient's cervix failed to dilate further than 9 cm. She was transferred to SVH at 1500 on February 19, 2005. Respondent told the on-call physician that the patient was 9 cm dilated at 0400 hours but had failed to progress further. The hospital delivered the baby by cesarian section on February 19, 2005.

Patient No. 33-27-24

28. On June 15, 2005, respondent sent a thirty-one year old VBAC patient to SVH from her birthing center. Respondent's transfer summary indicates the patient was in labor 20 hours with her membranes artificially ruptured at 2115 hours. The summary also indicates respondent gave the patient Stadol at 0500 , 1100 and 1350 hours. Respondent furnished the controlled substance Stadol to the patient without being supervised by a licensed physician and without having standardized procedures and protocols for furnishing medications to patients that were developed with and approved by a licensed physician. Respondent's records further indicate that the patient failed to dilate further than 9cm. Respondent's transfer history indicates that she sent the patient's prenatal papers, prenatal labs and labor summary with the transport team. Respondent did not otherwise communicate with the hospital staff when she transferred the patient's care to SVH. Respondent did not accompany the patient to SVH. At the hospital the patient was able to push the fetus down to a +2 station, but the fetal heart rate slowed and showed increasingly variable decelerations. In addition, the patient was exhausted. The patient was then consented to a vacuum assist and after three contractions, a viable baby boy was delivered.

Patient No. 33-87-41

29. On December 21, 2005, respondent sent a 37 year old patient who was 39 3/7 weeks pregnant to Simi Valley Hospital from her birthing center. Respondent's prenatal

notes indicate the patient had had 4 ultrasounds all documenting a marginal placenta previa. Marginal previa is the intrusion of the placenta into the margin or edge of the cervical opening associated with life-threatening hemorrhage before or during labor. The patient chart does not mention discussing the marginal previa with the patient, delivery options, risk of bleeding, or risk to mother or fetus. The chart does not mention a supervising physician or physician consult. The chart indicates the patient was a known GBS carrier and that she was given oral Amoxicillin and Ampicillin for 3 weeks before delivery. Respondent's labor notes show she gave the patient Ampicillin orally at 1840 hours on December 20, 2005. The standard of care for treating a patient with GBS is to give penicillin intravenously at the onset of labor and every 4 hours until birth. Respondent had no physician supervising her and had no standardized procedures and protocols developed with and pre-approved by a licensed physician in December 2005.

30. Respondent did not accompany the patient to SVH. Instead, she sent her with a note stating she was being transferred because of her failure to progress in labor, a low lying placenta, and loss of approximately 800 ml of blood. Respondent failed to advocate for the patient, to formulate a health care plan, or to give the patient the opportunity to make informed decisions about health care before it was provided.

Patient No. 33-96-84

31. On January 19, 2006, at 0230 hours, respondent delivered the 6 pound 3 ounce male infant of a 16 year old patient who was approximately 36 weeks pregnant. Labor and delivery occurred at respondent's birthing center, The Whole Woman, Inc., in Simi Valley. Respondent failed to deliver the placenta and kept the patient at her center for 8 hours after delivery of the baby. She then sent the patient "semi-shocky, with tachycardia and a Hemoglobin of 7 gms." to Simi Valley Hospital's emergency room without any communication to the receiving facility. The placenta had to be removed surgically and the patient needed and was given post-operative blood transfusions.

32. Respondent's labor and delivery records indicate she gave the patient 900 mg of Clindamycin at 2000 hours on January 18, 2006, 30 mg of Toradol at 0500 hours on

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January 19, 2006, 2 mg of Stadol at 0500 hours on January 19, 2006. Respondent's records further reflect that she gave the patient Pitocin at 0330 hours on January 19, 2006.

33. Respondent's patient records do not mention consultation with a supervising physician. Respondent had no supervising physician and no standardized procedures and protocols developed with and pre-approved by a licensed physician at the time she furnished the Clindamycin, Toradol and Stadol to the patient.

SECOND CAUSE FOR DISCIPLINE

(Furnishing or Ordering Controlled Substances or Dangerous Drugs without Standardized Procedures and Protocols)

34. Respondent is subject to disciplinary action under Code sections 2761, subdivision (a)(1)(unprofessional conduct), and 2836.1, subdivisions (a), (b), (c), (d), (f), (g) and (h) (nurse practitioner functioning pursuant to standardized procedures) in that she prescribed or furnished dangerous drugs and/or controlled substances to patients without having standardized procedures and protocols developed with and approved by a supervising physician. The circumstances are set forth more fully in paragraphs 24 through 33 above and incorporated herein as though set forth in full.

THIRD CAUSE FOR DISCIPLINE

(Furnishing or Ordering Dangerous Drugs or Controlled Substances without Being Supervised by a Licensed Physician)

35. Respondent is subject to disciplinary action under Code sections 2761, subdivision (a)(1)(unprofessional conduct), and 2836.1, subdivisions (d), (f) and (h) (nurse practitioner furnishing or ordering drugs) in that she prescribed or furnished dangerous drugs and/or controlled substances to patients without being supervised by a licensed physician. The circumstances are set forth more fully in paragraphs 24 through 33 above and incorporated herein as though set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing or Furnishing Drugs without Being So Directed by Physician)

36. Respondent is subject to disciplinary action under Code sections 2761,

subdivision (a)(1)(unprofessional conduct), and 2762, subdivision (a) (prescribing or furnishing controlled substances or dangerous drugs to self or others without being directed to do so by licensed physician) in that she prescribed or furnished dangerous drugs and/or controlled substances to patients or herself without being directed to do so by a licensed physician. The circumstances are set forth more fully in paragraphs 24 through 33 above and incorporated herein as though set forth in full.

FIFTH CAUSE FOR DISCIPLINE

(Suspension of License by Another California Health Care Licensing Board)

37. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1) and (4), for having her license, issued by the Medical Board of California, to practice midwifery suspended. The circumstances are that on March 1, 2007, the Medical Board of California obtained an Interim Suspension Order against respondent's license number LM 134. The order specifically prohibits respondent from providing any patient care pending the noticed hearing on the petition for interim suspension order.[2]

SIXTH CAUSE FOR DISCIPLINE

(Practicing Nursing without a Valid License)

38. Respondent is subject to disciplinary action under Code section 2761, subdivisions (a), (d) and (j), for violating sections 2795 and 2732 (practicing nursing without a valid license). The circumstances are as follows:

39. On January 25, 2007, as set forth more fully in paragraph 41 below above and incorporated herein by reference as though set forth in full, respondent was served with an order suspending her license and certificates to practice nursing in the State of California. On March 1, 2007, as set forth more fully above and incorporated herein by reference, the Medical Board of California obtained an Interim Suspension Order against respondent's license, issued by

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2. The Medical Board's hearing was noticed for March 1, 2007. However, when respondent appeared pro se and requested additional time, the matter was considered as an ex parte hearing and re-noticed for March 20, 2007. Thereafter, the parties stipulated to continue the hearing date to April 27, 2007. The interim suspension order remains in effect pending the outcome of the noticed hearing.

that board, to practice midwifery. On or about March 14, 2007, a search warrant was executed on respondent's premises known as The Whole Woman, Inc., at 2950 North Sycamore Drive in Simi Valley. The search warrant was based in part upon a consumer complaint about respondent's practice of midwifery. Evidence obtained during and following the execution of the search warrant indicated respondent continued to provide nursing services at her business, The Whole Woman Inc., after the interim suspension order was in effect. The nursing services respondent provided include but are not limited to the prescription of Ampicillin on March 5, 2007, for Whitney S.

SEVENTH CAUSE FOR DISCIPLINE

(Misleading Advertising)

40. Respondent is subject to disciplinary action under Code section 2761, subdivisions (a)(3) and (d), for advertising herself as a registered nurse and nurse practitioner in violation of Section 17500. The circumstances are that after the January 23, 2007 suspension order became effective, respondent's website, www.thewholewomaninc.com, continued to represent respondent as a Nurse Practitioner.

EIGHTH CAUSE FOR DISCIPLINE

(Violation of Interim Suspension Order)

41. Respondent is subject to disciplinary action under sections 2761, subdivisions (a) and (d), and 494, subdivision (i), in that she violated the Interim Suspension Order issued on January 23, 2007, and served on January 25, 2007, following the January 19, 2007 ex parte hearing. In addition to suspending all of respondent's nursing licenses pending the final outcome of the noticed hearing on the Petition for Interim Suspension Order, the January 23, 2007 interim suspension order directed respondent not to:

A. "Practice or attempt to practice any aspect of nursing in the State of California until the final decision of the Board following an administrative hearing;

B. Be present in any location which is maintained for the purpose of nursing, or at which nursing is practiced, for any purpose, except as a patient;

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C. Advertise, by any means, or hold herself out as practicing or available to practice nursing."

42. The Interim Suspension Order further directed:

"Respondent shall, no later than 12:00 p.m. on January 29, 2007, deliver to the Board, or its agent, for safekeeping pending a final administrative order of the Board in this matter, all indicia of her licensure as a registered nurse, and her certification as a public health nurse, as a nurse practitioner, and as a nurse practitioner furnisher, including but not limited to, her wall certificate(s) and wallet card(s) issued by the Board."

43. Following a February 13, 2007 hearing of respondent's motion for a continuance of the noticed hearing on the petition for interim suspension order, respondent was ordered to "comply with the order to deliver her indicia of licensure [to the Board] by February 23, 2007."

44. On March 15, 2007, following the March 13, 2007 noticed hearing on the petition for interim suspension order, respondent was ordered to deliver to the Board or its agent "no later than 12:00 p.m. on **March 22, 2007**, . . . for safekeeping pending a final administrative order of the Board in this matter, all remaining indicia of her licensure as a registered nurse, and her certifications as a public health nurse, as a nurse practitioner and as a nurse practitioner furnisher, including, but not limited to, her wall certificate(s) and wallet card(s) issued by the Board. **Framed wall certificates must either be disassembled and the unframed certificates delivered to the Board, or the wall certificates must be delivered to the Board in their frames, whichever method respondent chooses.**" (Emphasis original.)

45. Respondent has violated the Interim Suspension Order directing her not to practice or attempt to practice any aspect of nursing in the State of California until the final decision of the Board following an administrative hearing. The circumstances are that, from on or about January 26, 2007, to on or about March 28, 2007, respondent prescribed dangerous drugs and or controlled substances to patients whose names are known to respondent but not known to complainant. The prescriptions include, but are not limited to, a prescription issued on or about March 5, 2007, to Whitney S. for Ampicillin 250 mg.

46. Respondent has violated the Interim Suspension Order directing her not to be present in any location which is maintained for the purpose of nursing, or at which nursing is practiced, for any purpose, except as a patient. The circumstances are set forth in paragraph 45 above and incorporated herein as thought set forth in full.

47. Respondent has violated the Interim Suspension Order directing her not to advertise, by any means, or hold herself out as practicing or available to practice nursing. The circumstances are as follows:

a. Respondent's issuance of prescriptions as set forth more fully in paragraph 45 above are incorporated herein as though set forth in full.

b. In addition, respondent's website, www.thewholewomaninc.com, continues to advertise that she is a licensed Nurse Practitioner.

48. On three separate occasions – January 29, 2007, February 23, 2007, and March 22, 2007 – respondent has violated the Interim Suspension Order directing her to deliver to the Board of its agent all indicia of her licensure as a registered nurse as well as her certifications as a public health nurse, nurse practitioner and nurse practitioner furnisher.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 429440, issued to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen Marcia Kay McCulley;

2. Revoking or suspending Nurse Practitioner Certificate No. 9598, issued to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen Marcia Kay McCulley;

3. Revoking or suspending Nurse Practitioner Furnisher Certificate No. 9578, issued to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen Marcia Kay McCulley;

4. Revoking or suspending Public Health Nurse Certificate No. 49428, issued to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen Marcia Kay McCulley;

5. Ordering Marcia Kay McCulley to pay the Board of Registered Nursing

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the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

6. Taking such other and further action as deemed necessary and proper.

DATED: 3/29/07

RUTH ANN TERRY, M.P.H, R.N
Executive Officer
Board of Registered Nursing
State of California
Complainant

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Exhibit D

First-Amended Accusation No. 2007-249

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MARCIA KAY MCCULLEY 2950 N. Sycamore Dr. #201 Simi Valley CA, 93065 Registered Nurse License No. 429440 Nurse Practitioner Certificate No. 9578 Nurse Practitioner Furnishing Certificate No. 9578 Public Health Nurse Certificate No. 49428 Respondent.	Case No. 2007-249 OAH No. L 2007040643 **FIRST-AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant Ruth Ann Terry, M.P.H., R.N., brings this First-Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, State of California ("Board").

2. The Board is the state agency charged with administering and enforcing the statutes and regulations governing the practice of licensed registered nurses and nurse practitioners in the State of California.

3. On or about August 31, 1988, the Board issued Registered Nurse License No. 429440 to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen. The Registered

Nurse License was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

4. On or about December 19, 1997, the Board issued Nurse Practitioner Certificate No. 9578 to respondent. The Nurse Practitioner Certificate was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

5. On or about July 31, 1998, the Board issued Nurse Practitioner Furnisher Certificate 9578 to respondent. The Nurse Practitioner Furnisher Certificate was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

6. On or about September 4, 1992, the Board issued Public Health Nurse Certificate No. 49428 to respondent. The Public Health Nurse License was in full force and effect until suspended pursuant to the interim suspension order issued on January 23, 2007, and will expire on March 31, 2008, unless renewed.

JURISDICTION

7. First-Amended Accusation No. 2007-249 is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

8. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

9. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), of the Code, the Board may renew an expired license at any time within eight years after the expiration.

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10. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

". . . .

"(3) The use of advertising relating to nursing which violates Section 17500.

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

". . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

". . . .

"(j) Holding oneself out to the public or to any practitioner of the healing arts as a 'nurse practitioner' or as meeting the standards established by the board for a nurse practitioner unless meeting the standards established by the board pursuant to Article 8 (commencing with Section 2834) or holding oneself out to the public as being certified by the board as a nurse anesthetist, nurse midwife, clinical nurse specialist, or public health nurse unless the person is at the time so certified by the board."

11. Code Section 17500 provides in pertinent part:

"It is unlawful for any person, firm, corporation or association, or any employee thereof with intent directly or indirectly to . . . to perform services, professional or otherwise, or anything of any nature whatsoever or to induce the public to enter into any obligation relating

thereto, to make or disseminate or cause to be made or disseminated before the public in this state, or to make or disseminate or cause to be made or disseminated from this state before the public in any state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatever, including over the Internet, any statement, concerning . . . those services, professional or otherwise, or concerning any circumstance or matter of fact connected with the proposed performance . . ., which is untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading. . . ."

12. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient or other record pertaining to the substances described in subdivision (a) of this section."

13. Section 2836.1 provides in pertinent part that a nurse practitioner may furnish or order drugs or devices when all of the following apply:

"(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

"(b) The nurse practitioner is functioning pursuant to standardized procedure, as

defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

"(c)(1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

"(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

"(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

"(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

"(f)(1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

"(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the

nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order."

14. Section 2725 of the Code states:

"(a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

"(b) The practice of nursing within the meaning of this chapter [the Nursing Practice Act] means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, ...

"(c) 'Standardized procedures,' as used in this section, means either of the following:

"(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

"(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health

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care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

"The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing.

"(d) Nothing in this section shall be construed to require approval of standardized procedures by the Division of Licensing of the Medical Board of California, or by the Board of Registered Nursing."

15. Section 2726 of the Code states that "[e]xcept as otherwise provided herein, this chapter [the Nursing Practice Act] confers no authority to practice medicine or surgery."

16. Section 2795 of the Code states:

"Except as provided in this chapter [the Nursing Practice Act] , it is unlawful for any person to do any of the following:

"(a) To practice or to offer to practice nursing in this state unless the person holds a license in an active status .

"(b) To use any title, sign, card, or device to indicate that he or she is qualified to practice or is practicing nursing, unless the person has been duly licensed or certified under this chapter [the Nursing Practice Act]."

17. Section 2732 of the Code states:

"No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter [the Nursing Practice Act] except as otherwise provided in this act. . . ."

18. Section 2835 of the Code states:

"No person shall advertise or hold himself out as a 'nurse practitioner' who is not a nurse licensed under this chapter [the Nursing Practice Act] and does not, in addition, meet the standards for a nurse practitioner established by the board."

19. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

20. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

21. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the

client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

22. California Code of Regulations, title 16, section 1480, states:

"(a) 'Nurse practitioner' means a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforms to board standards as specified in Section 1484.

(b) 'Primary health care' is that which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease.

(c) 'Clinically competent' means that one possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice.

(d) 'Holding oneself out' means to use the title of nurse-practitioner."

23. California Code of Regulations, title 16, section 1485, provides in pertinent part:

"The nurse practitioner shall function within the scope of practice as specified in the Nursing Practice Act and as it applies to all registered nurses."

24. Code section 494, subdivision (i), provides in pertinent part:

"Failure to comply with an interim order issued pursuant to subdivision (a) or (b) shall constitute a separate cause for disciplinary action against any licentiate, and may be heard at, and as a part of, the noticed hearing provided for in subdivision (f). Allegations of noncompliance with the interim order may be filed at any time prior to the rendering of a

decision on the accusation. Violation of the interim order is established upon proof that the licentiate was on notice of the interim order and its terms, and that the order was in effect at the time of the violation. The finding of a violation of an interim order made at the hearing on the accusation shall be reviewed as a part of any review of a final decision of the agency."

25. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

26. **CONTROLLED SUBSTANCES**

A. "Ambien," a generic name for zolpidem tartrate, a nonbarbiturate hypnotic, is designated as a Schedule IV controlled substance by Health and Safety Code section 11057, subdivision (d)(32), and is categorized as a dangerous drug pursuant to Business & Safety Code section 4022.

B. "Apap/Hydrocodone Bitartrate" is a Schedule II narcotic substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug pursuant to Business and Professions Code section 4022.

C. "Homatropine/Hydrocodone" is a Schedule V substance pursuant to Health and Safety Code section 11058, subdivision (c)(2), and a dangerous drug pursuant to Business and Professions Code section 4022.

D. "Hydromet," a brand name for Homatropine/Hydrocodone, is a Schedule V substance pursuant to Health and Safety Code section 11058, subdivision (c)(2), and a dangerous drug pursuant to Business and Professions Code section 4022.

E. "Stadol," a brand name for Butorphanol, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (c)(3), and a dangerous drug pursuant to Business and Professions Code section 4022.

F. "Testosterone Cypionate," an anabolic steroid, is a Schedule III substance pursuant to Health & Safety Code section 11056, subdivision (f)(30), and a dangerous drug pursuant to Business and Professions Code section 4022.

27. **DANGEROUS DRUGS**

A. "Ampicillin" is an antibiotic used to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. It is a dangerous drug pursuant to Business and Professions Code section 4022.

B. "Amoxicillin" is an antibiotic used to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. It is a dangerous drug pursuant to Business and Professions Code section 4022.

C. "Clindamycin" is used primarily to treat infections caused by susceptible anaerobic bacteria. It is a dangerous drug pursuant to Business and Professions Code section 4022.

D. "Levoxyl," a brand name for Levothyroxine, is a synthetic form of thyroxine (thyroid hormone). It is a hormone replacement usually given to patients with thyroid problems, such as hypothyroidism. It is a dangerous drug pursuant to Business and Professions Code section 4022.

E. "Prochlorperazine" is a highly potent neuroleptic, commonly used to treat nausea. It is a dangerous drug pursuant to Business and Professions Code section 4022.

F. "Rhogam," a trade name for RHO(D) Immune Globulin, is used to prevent maternal sensitization to Rh D antigens on the surface of blood cells in a fetus. It is a dangerous drug pursuant to Business and Professions Code section 4022.

G. "Synthroid," a brand name for Levothyroxine, is a synthetic form of thyroxine (thyroid hormone). It is a hormone replacement usually given to patients with thyroid problems, such as hypothyroidism. It is a dangerous drug pursuant to Business and Professions Code section 4022.

H. "Toradol," a trade name for Ketorolac or ketorolac tromethamine, is a non-steroidal anti-inflammatory drug (NSAID) in the family of propionic acids, often used as an analgesic, antipyretic (fever reducer), and anti-inflammatory. It is a dangerous drug pursuant to Business and Professions Code section 4022.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 35-13-14 aka Patient R.M.)[1]

28. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she performed medical interventions, provided prenatal and labor care, and prescribed and administered medications for this patient without standardized procedures and protocols and without being supervised by a physician. The circumstances are as follows:

29. Respondent owned and operated The Whole Woman, Inc., a birthing center where she provided health care services to patients. Respondent's patient records indicate that on April 5, 2006, she began providing prenatal care to R.M., a thirty-nine year old female, approximately eleven weeks pregnant, for her first pregnancy. She estimated the patient's due date to be October 31, 2006. Respondent noted the following significant medical problems and risks: advanced maternal age, first pregnancy, vegetarian diet, anemia, and Jehovah Witness (no blood transfusions). Respondent failed to note urinary tract re-infections, bacterial vaginosis, postdates, and patient reluctance to follow the standard of care. On the health history summary respondent charted that the patient had no risk factors. Respondent recorded on her midwifery care checklist that she discussed with the patient her back-up OB physician, perinatal consult and individualized care plan. Respondent did not document a care plan and did not have a supervising OB physician. Respondent prescribed Cleocin vaginal cream for the patient on July 15, 2006. Respondent did not order any ultrasounds for the patient.

30. Respondent's labor notes and transfer summary note that at 2000 hours on November 7, 2006, the patient reported spontaneous rupture of yellow fluid. At 1100 hours on November 8, 2006, respondent's labor notes indicate she advised the patient to go to the hospital. The patient declined and asked respondent to perform an amnioinfusion. The labor notes indicate that respondent performed the amnioinfusion, that the patient had irregular contractions,

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1. Patient numbers were assigned upon hospital admission after care was transferred from respondent's birthing facility.

and that she failed to achieve any change in dilation from 2000 hours on November 8, 2006, to 1215 on November 9, 2006. Respondent administered 5 doses of Ampicillin during the patient's labor. At 1900 hours on November 9, 2006 the fetal heart rate was inaudible. Respondent recorded that the patient and her husband were probably aware that the fetus had died. At 1930 hours on November 9, 2006, the patient was admitted to Simi Valley Hospital ("SVH"), and was shocked at the news of the fetal demise. Labor was augmented with Pitocin and the stillborn infant was delivered vaginally at 0506 hours on November 10, 2006.

31. The Nurse Practice Act [NPA] requires all practicing nurse practitioners to have standardized procedures and/or protocols that have been developed by the nurse practitioner and a supervising physician to insure safe and competent patient care within the scope of practice for a nurse practitioner. Respondent's performance of medical interventions, provision of prenatal and labor care, and prescription and administration of medications without consulting with a supervising physician and without standardized procedures and/or protocols developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Incompetence and/or Gross Negligence: Patient No. 35-13-14 aka Patient R.M.)

32. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that her care and treatment of Patient R.M. demonstrated incompetence and/or gross negligence. The circumstances are as follows:

A. The matters alleged in paragraphs 28 through 31 are realleged and incorporated herein by reference as though fully set forth.

B. The nursing process is a basic skill for all nurses, including nurse practitioners. The nursing process includes making diagnoses, formulating care plans for each diagnosis, and evaluating the effectiveness of the care plans in order to improve and maintain the patient's health. Respondent failed to document care plans for the patient's

identified risk factors: anemia, vegetarianism, advanced maternal age, urinary tract re-infections, postdates and prolonged rupture of membranes.

THIRD CAUSE FOR DISCIPLINE

(Incompetence and/or Gross Negligence: Patient No. 35-13-14 aka Patient R.M.)

33. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that her care and treatment of Patient R.M. demonstrated incompetence and/or gross negligence. The circumstances are as follows:

A. The matters alleged in paragraphs 28 through 32 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent failed to formulate a care plan for the patient's diagnosed anemia. Diagnosis of anemia for a vegetarian pregnant woman requires a care plan to include follow-up testing and nutritional counseling. In cases of moderate to severe anemia further testing should be ordered to define the nature of the anemia. Moderate to severe iron deficiency anemia may increase the risk of neonatal death or stillbirth. A diet history and nutritional counseling with follow-up is the standard of care for women who are vegetarian during pregnancy.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence and/or Gross Negligence: Patient No. 35-13-14 aka Patient R.M.)

34. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that her care and treatment of Patient R.M. demonstrated incompetence and/or gross negligence. The circumstances are as follows:

A. The matters alleged in paragraphs 28 through 33 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent prescribed Cleocin 1% cream for the patient's Bacterial

Vaginosis found at 11 weeks gestation. The timing of the treatment was correct but the choice of drug was not. The preferred drug treatment for Bacterial Vaginosis in the second trimester of pregnancy is Metronidazole.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence and/or Gross Negligence: Patient No. 35-13-14 aka Patient R.M.)

35. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that her care and treatment of Patient R.M. demonstrated incompetence and/or gross negligence. The circumstances are as follows:

A. The matters alleged in paragraphs 28 through 34 are realleged and incorporated herein by reference as though fully set forth.

B. As the patient's primary health care provider, respondent was responsible and accountable for the continuity of health care regardless of the presence or absence of disease. Respondent failed to accompany the patient to the hospital and provided none of the patient's labor records at the time the patient's care was transferred.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient No. 35-13-14 aka Patient R.M.)

36. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that her care and treatment of Patient R.M. demonstrated incompetence and/or gross negligence. The circumstances are as follows:

A. The matters alleged in paragraphs 28 through 35 are realleged and incorporated herein by reference as though fully set forth.

B. As the patient's primary health care provider, respondent was responsible and accountable for the continuity of health care regardless of the presence or absence of disease. Respondent failed to communicate to the patient the nature of the problem that

precipitated the patient's transfer of care. Her failure to communicate to the patient that the fetus had died was unprofessional and placed the patient at risk for further complications.

SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

37. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, for gross negligence in that she failed to secure or consult with a supervising physician while providing prenatal and labor care to this patient whose medical history and pregnancy were non-routine. The circumstances are as follows:

38. The patient received prenatal care at Kaiser Hospital from November 28, 2005, to June 15, 2006. Kaiser's prenatal care records identified the patient had a history of HPV on a pap smear and a recent history of right breast nipple bloody discharge. Respondent provided prenatal care for this patient from June 2, 2006, to July 8, 2006. Respondent's prenatal records indicate that during the first prenatal visit she discussed her OB physician back-up with the patient. The prenatal records also indicate that respondent identified anemia as a pregnancy risk.

39. Respondent's labor notes and transfer summary for this patient report that Patient J.M. presented at the birthing center at 0315 hours on July 8, 2006, shaking, nauseous and vomiting, 5 cm dilated, 50% effaced and 0 station. At 0700 hours the patient was still just 5 cm dilated. At 1200 hours the patient was 6 cm dilated; at 2100 hours the patient was 7 cm dilated; at 0630 hours on July 9, 2006, the patient was 9 cm dilated. At 1600 hours on July 9, 2006, the patient was 10 cm (fully) dilated. The first notation of pushing efforts was at 1330 hours on July 9, 2006; however, the patient and her support person recalled the patient's pushing for approximately 24 hours starting at approximately 1740 hours on July 8, 2006. Respondent noted the spontaneous rupture of membranes at 1730 on July 9, 2006. The fluid was noted as clear.

Respondent performed an episiotomy[2] in the tub at 1600 hours on July 9, 2006, when the water was so clouded with blood that respondent could not have visualized the perineum. At 1759 on July 9, 2006, a male infant was delivered. The infant was covered with meconium[3], was blue and nonresponsive, and was given oxygen for some 10 minutes. Respondent administered Ampicillin, Xylocaine and Methergine to the patient. No administration of any pain medication was recorded. At 2100 hours on July 9, 2006, respondent surgically repaired a fourth degree laceration at the episiotomy site. At 2220 hours respondent described the patient as agitated, jittery and shaky. The only fluids the patient had been given during labor were Gatorade, Hi C water, carbohydrate gels and glucose tablets.

40. The patient and her infant remained at the birthing center until 1630 hours on July 10, 2006, when respondent released them to go home. Respondent presented at Kaiser on July 11, 2006, complaining she was not feeling right. She was sent to the emergency room where blood tests showed she had severe anemia. She was immediately transfused with four units of blood and given triple antibiotics. The patient returned to Kaiser several times to repair the episiotomy. The patient reports she is incontinent and will need to undergo reconstructive surgery to repair the episiotomy.

41. Respondent's performance of medical interventions, provision of pre-pregnancy, prenatal and labor care, and prescription and administration of medications without having standardized procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

42. Respondent is subject to disciplinary action under sections 2761,

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2. Incision of peritoneum at end of second stage of labor to avoid laceration of perineum and to facilitate delivery.

3. Meconium is the first feces of the fetus/newborn. It is a greenish color. The fetus may aspirate (inhale) it from the amniotic fluid. Meconium aspiration usually occurs when the fetus is stressed during labor, particularly if the fetus is past its due date.

subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, for gross negligence in that she failed to secure or consult with a supervising physician while providing prenatal and labor care to this patient whose medical history and pregnancy were non-routine. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 41 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent charted discussing her physician "back-up" with the patient during the first prenatal visit. Respondent had no supervising physician at the time. Respondent falsely represented to the patient her ability to practice safely as a nurse or nurse practitioner. Her misrepresentation is an extreme departure from the standard of care and constitutes gross negligence.

NINTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

43. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she was grossly negligent in failing to completely and accurately record the treatment and medications she provided. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 42 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent failed to accurately chart on the labor record the patient's pushing efforts early in the labor and pain medications respondent administered. The onset of pushing efforts is an important factor in evaluating maternal fatigue and labor progress. Nurses are obligated to chart the administration of all treatments and medications to ensure patient safety and healthy outcomes. Respondent's failure to chart all of the medications and interventions she provided is an extreme departure from the standard of care.

TENTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

44. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she was grossly negligent in the care and treatment of this patient. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 43 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent failed to accurately document the patient's estimated blood loss during and after delivery. Respondent documented the patient lost 300 ml of blood during immediate recovery. Usual amount of blood loss during a normal vaginal delivery is 300 to 500 ml. Since respondent performed the episiotomy in a tub full of bloody water, she had no way to accurately estimate the blood loss. In addition, respondent documented that the patient reported having a postpartum bleed at home. Both the patient and her husband denied reporting such an event to respondent. Respondent's inaccurate and false documentation is an extreme departure from the standard of care.

ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

45. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1 and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she was grossly negligent in failing to secure or consult with a supervising physician while providing labor and postpartum care to this patient whose medical history and pregnancy were non-routine. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 44 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent failed to consult with a licensed physician during her labor and postpartum care of this patient. During labor the presence of arrested labor, desire for

medication, and severe lacerations of the vagina or perineum require consultation. Agitation, shakiness and jitteriness are abnormal symptoms during postpartum recovery that require consultation with a physician. Respondent's failure to consult with a supervising physician regarding these abnormal characteristics is an extreme departure from the standard of care.

TWELFTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

46. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 0012000323. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 45 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent's management of the patient's labor demonstrates poor skills at recognizing and understanding abnormal labor patterns. Respondent's documentation of the onset of active labor is inaccurate. Respondent failed to monitor the fetal heart rate sufficiently often for a first-time pregnant woman with protracted labor. Respondent decided to repair a fourth degree laceration without consulting with or being assisted by a physician.

THIRTEENTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

47. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 0012000323. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 46 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent used an electrical breast pump, plugged into an AC socket, continuously for 45 minutes to stimulate uterine contractions while the patient's body was submerged in the birthing tub. There is no indication in the patient's records that respondent monitored the frequency and duration of contractions and the fetal heart rate while using this type of stimulation. There is no indication of respondent's awareness of the patient's risk for electrical shock from contact with electrical devices while submerged in water. Respondent's conduct is an extreme departure from the standard of care.

FOURTEENTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

48. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 0012000323. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 47 are realleged and incorporated herein by reference as though fully set forth.

B. Urinary catheterization[4] is a basic skill for all nurses. Usually if a laboring patient is unable to empty a filled bladder, a straight catheter is inserted. If the situation occurs again and birth is not imminent, an indwelling catheter is placed to avoid repetitive procedures. The catheter is then removed during the second stage of labor when the patient is pushing the baby through the birth canal. Respondent's numerous catheterizations of the patient during labor put the patient at high risk for a UTI and for urethral trauma. The catheterizations also caused the patient pain. Respondent's labor notes do not clearly state what type of catheter she used.

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4. Catheterization is the passing of a tubular instrument to allow passage of fluid from or into a body cavity or blood vessel. It is especially designed to be passed through the urethra into the bladder to drain it of retained urine.

FIFTEENTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

49. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 0012000323. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 48 are realleged and incorporated herein by reference as though fully set forth.

B. Classic symptoms of hypovolemic shock include restlessness, cool and clammy skin, and weak and rapid pulse. Respondent failed to recognize the signs and symptoms of hypovolemic shock during the patient's postpartum recovery. Instead, she diagnosed and treated the patient for hyperglycemia. Left untreated, hypovolemic shock can be fatal. Respondent's failure to recognize, diagnose and treat the early symptoms of hypovolemic shock demonstrates her lack of knowledge and skills and is an extreme departure from the standard of care.

SIXTEENTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 0012000323 aka Patient J.M.)

50. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 0012000323. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 49 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent's attempts to resuscitate the infant demonstrate her lack of skills in infant resuscitation.

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SEVENTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient No. 0012000323 aka Patient J.M.)

51. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 0012000323. The circumstances are as follows:

A. The matters alleged in paragraphs 37 through 50 are realleged and incorporated herein by reference as though fully set forth.

B. Registered nurses and nurse practitioners have a duty to advocate for their clients and to give their clients the opportunity to make informed decisions about health care before it is provided. Nurses are ethically bound to be honest. Respondent's refusal of the patient's repeated requests to be transferred to the hospital demonstrates her lack of knowledge and failure to exercise precaution in a situation that she knew, or should have known, could have jeopardized the patient's life or health.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 32-58-03 aka Patient L.S.)

52. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she failed to communicate with any supervising physician regarding the patient's high risk status and failed to accurately and comprehensively document this patient's record of care. The circumstances are as follows:

53. Respondent started providing pre-pregnancy counseling and exams for Patient No. 32-58-03 on March 29, 2005. Respondent sent the patient for laboratory testing, prescribed Progesterone to enhance her fertility, and treated the patient with Doxycycline for a urinary tract infection ("UTI"). The patient's prenatal care started on September 23, 2005, and ended on May 10, 1006. During that period respondent charted that the patient had a history of frequent UTI's and kidney stones, depression and herpes infection. Respondent documented

discussing her "back-up OB physician" with the patient. Respondent prescribed or administered Progesterone, Doxycycline, Macrobid, Ceclor and Ciprofloxacin during the prenatal care period. Respondent did not document nursing care plans for the pregnancy risks and problems she identified.

54. Respondent's labor notes and transfer summary indicate the patient presented to the birthing center at 0800 hours on May 10, 2006, reporting spontaneous rupture of membranes ("SROM") of clear fluid at 0300 hours and irregular mild uterine contractions. The patient recalled receiving some pain medication at approximately 0300 hours on May 11, 2006, but no pain medication is listed on respondent's labor notes. At 0900 hours, 30 hours after SROM, respondent administered Ampicillin intravenously. At 2100 hours , 42 hours after SROM, the labor notes indicate the patient was 10 cm dilated, 100% effaced, and +2/+3 station. Contractions were moderate to strong every 4 to 5 minutes but the patient had no urge to push. Respondent gave the patient a third dose of Ampicillin intravenously. The patient recalls asking at approximately 0030 hours on May 12, 2006, to be transferred to the hospital. Respondent's labor notes do not record the request. The labor notes indicate respondent advised the patient at approximately 0100 hours that she might need to transfer her to the hospital. The patient continued pushing from 0045 hours until 0300. At 0415 hours the patient was transported from the birthing center via ambulance to SVH. Her membranes had been ruptured for 49 hours, and the last time she received an antibiotic was at 2100 hours on May 11, 2006. Respondent indicated the reason for transfer was fatigue, discouragement and arrest of second stage labor. She noted anemia as significant past history but did not mention prolonged rupture of membranes, history of herpes and depression, UTI's in pregnancy and history of kidney stones. Respondent documented administration of Ampicillin and intravenous therapy but did not document administering Darvocet or other pain medications. Respondent's labor notes were not sent with the patient, and respondent did not communicate directly with the on-call physician at SVH about the patient's treatment or condition. The patient's male infant was delivered at SVH with a vacuum assist on May 12, 2006.

55. Respondent's performance of medical interventions, provision of pre-

pregnancy, prenatal and labor care, and prescription and administration of medications without having standardized procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

NINETEENTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 32-58-03 aka Patient L.S.)

56. Respondent is subject to disciplinary action under sections 2761, subdivisions (a)(1) and (d), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that her care and treatment of this patient was grossly negligent. The circumstances are as follows:

A. The matters alleged in paragraphs 52 through 55 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent charted she had discussed her physician "back-up" with the patient during the first prenatal visit. Respondent had no supervising physician at the time. Respondent falsely represented to the patient her ability to practice safely as a nurse or nurse practitioner. Her misrepresentation is an extreme departure from the standard of care and constitutes gross negligence.

TWENTIETH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 32-58-03 aka Patient L.S.)

57. Respondent is subject to disciplinary action under sections 2761, subdivisions (a)(1) and (d), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that her care and treatment of this patient was grossly negligent. The circumstances are as follows:

A. The matters alleged in paragraphs 52 through 56 are realleged and incorporated herein by reference as though fully set forth.

B. Nurse practitioners are providers of primary health care. As such, they have a duty to be responsible for the continuity of health care regardless of the presence or absence of disease. Respondent's failure to communicate with the on-call physician before

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sending the patient to the hospital is an extreme departure from the standard of care and constitutes gross negligence.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 32-58-03 aka Patient L.S.)

58. Respondent is subject to disciplinary action under sections 2761, subdivisions (a)(1) and (d), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that her care and treatment of this patient was grossly negligent. The circumstances are as follows:

A. The matters alleged in paragraphs 52 through 57 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent's failure to consult with any physician during the patient's abnormal labor curve and prolonged rupture of membranes is an extreme departure from the standard of care.

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 32-58-03 aka Patient L.S.)

59. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 32-58-03. The circumstances are as follows:

A. The matters alleged in paragraphs 52 through 58 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent failed to recognize a history of Herpes Simplex Virus [HSV] as a risk factor during her provision of prenatal care. An outbreak of HSV during labor would require a cesarean delivery. Respondent's failure to recognize the potential problem, make any assessments for its recurrence, or develop a care plan for this risk demonstrates her lack of knowledge and skills.

C. Renal infection can cause septic shock and may be associated with

premature and low birth-weight infants. Respondent diagnosed the patient with UTI's six times during her prenatal care. Knowing that the first treatment failed to eradicate the infection, respondent treated the patient twice with the same antibiotic for the same bacterial organism infection. The standard of care for treating UTI's unresponsive to the antibiotic administered is to consult with a supervising physician or to treat with prophylaxis antibiotics throughout the remainder of the pregnancy.

D. Prolonged rupture of membranes, defined as membranes ruptured for 12 hours or longer, places the mother at risk for infection, abruptio placenta and neonatal sepsis. Respondent waited 30 hours before giving the patient Ampicillin and 49 hours to transfer the patient to the hospital. In addition, respondent failed to document prolonged rupture of membranes as a reason for the transfer on her transfer summary.

E. Respondent inaccurately described the fetal heart rate as "reactive."

F. Respondent failed to formulate nursing care plans for identified problems and risks during the patient's pregnancy and labor. Her failure to do so precluded her from evaluating her success in resolving the identified problems and evaluating the accomplishment of her goals in caring for the patient.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 34-30-04 aka Patient E.H.)

60. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she was grossly negligent in her treatment of this patient. The circumstances are as follows:

61. Respondent provided prenatal treatment for Patient No. 34-30-04 with an estimated delivery date of May 4, 2006, starting on November 18, 2005, and ending on April 26, 2006. During this period respondent performed assessments, exams, tests and artificial rupture of membranes, and ordered laboratory tests and ultrasounds and obtained cultures; prescribed iron supplements and Spetazole cream; and identified problems or risks of anemia, history of smoking, mother with history of breast cancer, abnormal pap smears, history of depression and

use of Zoloft before the pregnancy and ringworm. Missing from the prenatal care records is a diagnosis of anorexia at age 16 and extreme low weight before the pregnancy started. Also missing from the prenatal care records are nursing care plans for all of the identified pregnancy risks or problems.

62. Respondent's labor notes and transfer summary indicate the patient presented to the birthing center on May 1, 2006, where a cervical exam indicated she was 5 cm dilated, 90% effaced and -1 station. Respondent artificially ruptured the patient's membranes at 1100 hours but did not document the amount or color of the fluid. Between 1045 hours on May 1, 2006, and 0030 hours on May 2, 2006, the patient progressed to complete dilation, complete effacement and +2 station. Respondent documented the administration of Stadol, Toradol and Clindamycin. She did not document administration of Pitocin. Starting at 1000 hours on May 2, 2006, respondent failed to perform any labor assessments, even though the first notation of meconium-stained amniotic fluid was charted at that time. The labor record is missing documentation of assessments of the patient's pulse and other vital signs throughout the labor. The patient's temperature was assessed for the first time 15 hours after her membranes were ruptured. At 1200 the family was transferred via ambulance to SVH. The transfer summary indicates the reasons for transfer were "fatigue, poor labor pattern, arrest of second stage." It does not include prolonged ROM and meconium-stained amniotic fluid. When respondent telephoned SVH to advise of the transfer, the nurse who received the call advised her to call the on-call physician since nurses are not allowed to accept the transfer. Respondent did not telephone the on-call physician. SVH admitting records indicate the patient arrived between 1200 and 1300 hours on May 2, 2006, was dilated to 5 cm, 80% effaced, and 0 station. The fetus was tachycardic with repetitive variable decelerations and in direct occiput posterior position. The infant girl was delivered by c-section at 1425 hours on May 2, 2006. A large amount of dark meconium fluid was suctioned.

63. Respondent's performance of medical interventions, provision of prenatal and labor care, and prescription and administration of medications without having standardized

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procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 34-30-04 aka Patient E.H.)

64. Respondent is subject to disciplinary action under sections 2761, subdivisions (a)(1) and (d), and 2762, subdivision (a), for violating Code sections 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 34-30-04. The circumstances are as follows:

A. The matters alleged in paragraphs 60 through 63 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent charted discussing her physician "back-up" with the patient during the first prenatal visit. Respondent had no supervising physician at the time. Respondent falsely represented to the patient her ability to practice safely as a nurse or nurse practitioner. Her misrepresentation is an extreme departure from the standard of care and constitutes gross negligence.

C. Respondent abandoned her patient by transferring her to the hospital without first communicating with the on-call physician. Respondent's failure to communicate with the receiving doctor at SVH is an extreme departure from the standard of care and constitutes gross negligence.

D. Respondent failed to consult with any physician regarding the patient's slow labor pattern and prolonged rupture of membranes. Respondent's failure to consult with a licensed physician regarding abnormal labor characteristics is an extreme departure from the standard of care and constitutes gross negligence.

E. Respondent failed to chart on the labor record the administration of Pitocin and color of amniotic fluid when she artificially ruptured the patient's membranes. Nurses providing care during labor are required to chart the administration of all treatments, medications and events that may help assess fetal well-being. Accurate

documentation is a basic nursing standard designed to insure patient safety. Respondent's failure to document the assessments demonstrates her lack of knowledge and skills and constitutes incompetence. If respondent did not perform the assessments, her conduct is an extreme departure from the standard of care.

F. Respondent charted the onset of labor as 0130 on April 29, 2006, on the labor notes, but indicated on the transfer summary it was at 1000 hours on May 1, 2006. If the discrepancy was unintentional, it demonstrates respondent's lack of knowledge and skills. If respondent falsified the record, her conduct was an extreme departure from the standard of care and constituted gross negligence.

G. Respondent failed to recognize the patient's history of anorexia and current under-weight status as potential patient problems. A psychosocial assessment is a routine prenatal assessment that is missing from the patient's prenatal record. In addition, respondent failed to recognize and consult with a physician regarding the patient's prolonged rupture of membranes, prolonged labor and failure to progress in labor.

H. Respondent failed to apply the nursing process in the care of this patient. She failed to construct care plans for the identified problems, to perform essential skills in light of those plans, and to evaluate the care plans for effectiveness.

I. Respondent failed to record and/or perform critical assessments such as vital signs throughout the patient's labor. Assessing the maternal temperature is critical in determining the well-being of both mother and baby when the membranes have been ruptured and labor is prolonged.

J. Respondent incorrectly evaluated the patient's labor progress. Pelvic exams to evaluate the progress of labor are an elemental skill of any labor nurse. Respondent's error demonstrates her lack of knowledge and skills and constitutes incompetence.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 33-96-84 aka Patient A.W.)

65. Respondent is subject to disciplinary action under sections 2761,

subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she was grossly negligent in her treatment of this patient. The circumstances are as follows:

66. Respondent provided prenatal treatment for Patient No. 33-96-84 at her birthing center beginning on August 26, 2005, and ending on January 19, 2006. On August 26, 2005, the sixteen year old patient was 15 weeks pregnant with an estimated delivery date of February 14, 2006. During the course of prenatal care respondent performed exams, ordered laboratory tests, obtained cultures, and prescribed drugs including macrobid and ampicillin. Respondent failed to record laboratory results of more than one urine analysis with culture and sensitivities, a plan of care with evaluations for each problem identified in the pregnancy, consultation with any physician, and the administration or prescription of Vicodin which the patient reported to the admitting physician at SVH.

67. Respondent's labor notes and transfer summary report that labor started at 1700 hours on January 18, 2006. At 2000 hours respondent administered intravenous fluids and Clindamycin while the patient was in first stage labor. At 2200 hours respondent artificially ruptured the patient's membranes. At 0230 a normal spontaneous vaginal delivery of in infant male occurred. One hour later without delivery of the placenta, respondent administered Pitocin intravenously. At 0500 hours respondent administered Toradol and Stadol intravenously. The last set of vital signs was recorded at 0600 hours. Respondent's records indicate she had the patient transferred to SVH 8 hours postpartum. The hospital records show the patient was admitted at 1100 hours on January 19, 2006, eight and one half hours postpartum, and was admitted for retained placenta. The patient was transfused with 3 units of blood, and the placenta was extracted in the operating room. The patient was hospitalized for 12 days without her infant.

68. Respondent's patient records do not mention consultation with a supervising physician. Respondent had no supervising physician and no standardized procedures and protocols developed with and pre-approved by a licensed physician at the time she furnished the Clindamycin, Toradol and Stadol to the patient. The Nurse Practice Act [NPA] requires all practicing nurse practitioners to have standardized procedures and/or protocols that have been

developed by the nurse practitioner and a supervising physician to insure safe and competent patient care within the scope of practice for a nurse practitioner. Respondent's performance of medical interventions, provision of prenatal and labor care, and prescription and administration of medications without having standardized procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 33-96-84 aka Patient A.W.)

69. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1) and (d), and 2762, subdivision (a), 2836.1 and 2725, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 33-96-84. The circumstances are as follows:

A. The matters alleged in paragraphs 65 through 68 are realleged and incorporated herein by reference as though fully set forth.

B. Nurse practitioners are trained and licensed to manage the care of normal pregnancies and to consult with supervising physicians when high risk factors are present. This patient presented with numerous UTI's throughout her prental care, but respondent failed to document a care plan or physician consultation. Respondent's failure to consult with a supervising physician when the patient manifested health conditions that placed her pregnancy at risk for premature delivery is an extreme departure from the standard of care and constitutes gross negligence.

C. Respondent failed to document significant data on the patient's chart such as results of various urinalyses and important patient assessments. She also failed to act as a patient advocate when she transferred the patient from her birthing center to the hospital without communicating with the on-call hospital physician. Respondent's conduct demonstrates her lack of knowledge and skills and constitutes incompetence.

D. Formulating a care plan for each diagnosis is part of the nursing process.

The nursing process is a basic skill for all nurses including nurse practitioners. The nursing process includes an evaluation of the effectiveness of care plan interventions and goals. Respondent's failure to document a care plan for a patient with high risk factors (recurrent UTI's and teen pregnancy) demonstrates her lack of skills and knowledge and constitutes incompetence.

E. The standard of care requires nurse practitioners to consult with a supervising physician regarding further treatment and a care plan for unresponsive treatment of UTI's. Respondent's failure to consult with a supervising physician under these circumstances is an extreme departure from the standard of care and constitutes gross negligence.

F. Respondent performed a test for preterm labor during the 35th week of gestation. The recommended guideline for the use of this test is no later than 34 weeks, 6 days of gestation.

G. Respondent failed to chart any special needs in the records of this pregnant teenager.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 33-87-41 aka Patient M.C.)

70. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that her treatment of this patient was grossly negligent. The circumstances are as follows:

71. Respondent began providing prenatal treatment for Patient No. 33-87-41 at her birthing center on May 18, 2005. The thirty-seven year old patient's due date was December 25, 2005. Among the pregnancy risk factors respondent identified with the pregnancy were: history of rapid labors, advanced maternal age, history of abnormal pap smears, hyperlipidemia, marginal placenta previa, and testing positive for group B streptococcus (GBS). Respondent failed to document a care plan for any of these issues or an evaluation of any interventions. For example, respondent ordered ultrasounds but failed to record all of the results. Respondent did

not consult with a physician or document the status of vaginal bleeding during prenatal visits. Respondent did not record any discussion with the patient regarding plans for delivery with marginal previa. Respondent prescribed Amoxicillin without a diagnosis to correlate with the intervention. Respondent performed six cervical exams before the patient was in active labor.

72. Respondent's labor notes and transfer summary report that the patient presented to the birthing center at 1840 hours on December 20, 2005, reporting labor had started forty minutes earlier and that she had bled approximately 1 cup at home. The patient reported she had been given Ampicillin by mouth for her GBS+ status. The records reported respondent had bled approximately 800 ml at the birthing center, and that she had received 2 liters of lactated ringers intravenous fluid in the last 6 hours before she was transferred to SVH. The patient's male infant was delivered at SVH by c-section at 0404 hours.

73. The Nurse Practice Act [NPA] requires all practicing nurse practitioners to have standardized procedures and/or protocols that have been developed by the nurse practitioner and a supervising physician to insure safe and competent patient care within the scope of practice for a nurse practitioner. Respondent's performance of medical interventions, provision of prenatal and labor care, and prescription and administration of medications without having standardized procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

74. The standard of care for patients with marginal placenta previa in the third trimester of pregnancy is to avoid vaginal and rectal examinations because they may precipitate uncontrollable hemorrhage. Physician consultation is mandated in cases of third trimester bleeding. Respondent's performance of cervical examinations and failure to consult with a physician when the patient reported bleeding at home when active labor started are extreme departures from the standard of care and constitute gross negligence..

75. The standard of care requires nurse practitioners to consult with a supervising physician when a patient has health problems that exceed their scope of practice. Marginal placental previa is a high risk factor that necessitates either consultation and/or transfer of care to a physician. Respondent failed to communicate with any supervising physician

regarding the marginal placental previa found on numerous obstetrical ultrasounds. Respondent failed to discuss with her patient the risks of attempting vaginal delivery with this condition. Respondent failed to consult with and transfer the patient to a hospital physician when the patient reported upon arrival at the birthing center that she had gushed blood 30 minutes before. This type of bleeding could be life-threatening. In addition, respondent's transfer summary stated the reason for the transfer was "failure to progress in labor" and "bleeding with a low-lying placenta." Respondent's failure to consult with or transfer the patient to a physician and failure to educate the patient regarding the delivery risks for the condition of marginal placenta previa are extreme departures from the standard of care and constitute gross negligence.

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

(Incompetence: Patient No. 33-87-41 aka Patient M.C.)

76. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2725 and 2836.1, and California Code of Regulations, title 16, sections 1443, 1443.5, 1480 and 1485, in that she failed to document a care plan for each of the patient's high risk factors or pregnancy problems. The circumstances are as follows:

A. The matters alleged in paragraphs 70 through 75 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent failed to identify care plans for the high risk factors she identified, including marginal placenta previa, positive GBS, advanced maternal age, history of rapid labors, and history of abnormal pap smears. Respondent's failure to develop care plans and to evaluate the effectiveness of interventions for identified risk factors demonstrates her lack of knowledge and skills and constitutes incompetence.

TWENTY NINTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 33-87-41 aka Patient M.C.)

77. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and

was grossly negligent in her care and treatment of Patient No. 33-87-41. The circumstances are as follows:

A. The matters alleged in paragraphs 70 through 76 are realleged and incorporated herein by reference as though fully set forth.

B. Respondent knew of the patient's marginal placenta previa from multiple obstetrical ultrasounds, but chose to perform numerous vaginal exams beginning on December 5, 2005. By repeatedly performing an intervention that is contraindicated respondent endangered the safety of the pregnant woman and her fetus. Her conduct is an extreme departure from the standard of care and constitutes gross negligence and incompetence.

C. Respondent prescribed Ampicillin by mouth to treat the patient's positive GBS status. The standard of care is to administer Penicillin intravenously every four hours throughout active labor. Alternate therapy is Ampicillin intravenously every four hours throughout active labor. Respondent practiced unsafe medicine by failing to follow the standard of care for proven treatment of GBS. Her conduct placed the newborn at risk for unnecessary complications. Respondent's conduct demonstrates her lack of knowledge and skills and constitutes incompetence.

D. Respondent failed to document a plan for follow-up ultrasounds after receiving abnormal findings on the November 2, 2005 ultrasound; failed to document a plan for subsequent assessments of abnormal measurement of amniotic fluid on the December 5, 2005 ultrasound; failed to document assessments of vaginal bleeding during prenatal visits; and failed to discuss risk factors and a delivery plan with a patient who had a diagnosis of "marginal placenta previa" at 33 weeks gestation. Respondent's interventions exposed both the mother and fetus to severe and life-threatening complications. Her conduct was an extreme departure from the standard of care and constitutes gross negligence.

E. A nurse practitioner should understand the seriousness of the diagnosis of marginal placenta previa. Respondent's failure to consult at appropriate times with a

physician and her inaccurate recording of the patient's diagnosis on the transfer summary demonstrate her lack of understanding of the condition (marginal placenta previa) and the serious complications that can result from this condition.

THIRTIETH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 33-27-24)

78. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she was grossly negligent in her care and treatment of Patient No. 33-27-24. The circumstances are as follows:

79. Respondent began providing prenatal treatment for Patient No. 33-27-24 at her birthing center on October 18, 2004. The patient's estimated delivery date was June 15, 2005. In the prenatal record respondent noted the patient's medical history as follows: C-section delivery in 1975 and vaginal delivery in 2000, mild mitral valve prolapse (no notation of medical evaluations), asthma, abnormal pap smears, positive ANA (antinuclear antibodies), and history of Herpes Simplex Virus. From this history respondent concluded the patient had "no known factors to preclude an out-of-hospital birth." In November 2004, respondent diagnosed the patient with vaginitis without documenting any laboratory tests or results or treatment. In January 2005 respondent ordered a urinalysis but never documented the results on the prenatal chart. In April 2005 the patient reported she had been involved in a motor vehicle accident. Respondent failed to document any assessments for the presence of vaginal bleeding, trauma, or abdominal cramping; any education about pre-term labor symptoms; or results of third trimester testing for diabetes. On May 12, 2005, the patient complained of dizziness, but respondent did not record any vital signs. On May 18, 2005, respondent ordered a urinalysis, but failed to document the results.

80. According to respondent's labor notes, the patient presented at the birthing center at 2015 hours on June 13, 2005 in active labor, 4-5 cm dilated and -1 station. Labor progressed slowly to 9 cm and +2 station at 0800 hours on June 14, 2005. Respondent artificially ruptured the patient's membranes at 2110 hours on June 13, 2005, and noted the fluid was clear.

Respondent administered Stadol to the patient at 0600 hours on June 14, 2005. Respondent gave the patient a second dose of Stadol at 1100 hours, when the patient was still dilated to only 9 cm. Respondent administered a third dose of Stadol at 1330 hours. Respondent failed to document the patient's respirations or pushing efforts. Respondent's transfer summary states that she sent the patient's prenatal papers, prenatal labs and labor summary to SVH with the transport team. But respondent did not accompany the patient or communicate directly with the on-call physician at SVH. The patient reported she had been pushing for six hours and was exhausted. The patient's baby was delivered vaginally with vacuum assistance at the hospital at 1423 hours.

81. Respondent's performance of medical interventions, provision of prenatal and labor care, and prescription and administration of medications without having standardized procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

THIRTY-FIRST CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 33-27-24)

82. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 33-27-24. The circumstances are as follows:

A. The matters alleged in paragraphs 78 through 81 are realleged and incorporated herein by reference as though fully set forth.

B. During the prenatal care of this patient respondent failed to recognize and understand the possible serious consequences for a patient outside of a hospital who had had a previous c-section delivery.

C. Respondent failed to document a detailed assessment of the patient's history of mitral valve prolapse, on-going assessments of symptoms such as anxiety or chest pain, or vital signs even on May 12, 2005, when the patient reported "dizziness." Respondent failed to consult a physician regarding the patient's "dizziness."

D. Respondent failed to document or evaluate the effectiveness of a plan of care for the following risk factors she had identified for this patient: history of mitral valve prolapse, positive ANA (antinuclear antibodies) with a speckled pattern, diagnosis of anemia considering the patient was a vegetarian, and history of Herpes Simplex Virus.

THIRTY-SECOND CAUSE FOR DISCIPLINE

(Incompetence: Patient No. 33-27-24)

83. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2725 and 2836.1, and California Code of Regulations, title 16, sections 1443, 1443.5, 1480 and 1485, in that she failed to accurately and comprehensively document the record of care for Patient No. 33-27-24. The circumstances are as follows:

A. The matters alleged in paragraphs 78 through 82 are realleged and incorporated herein by reference as though fully set forth.

B. Accurate and comprehensive documentation of patient events on the medical record is a basic nursing standard and a vital aspect of nursing practice. Respondent failed to document in her prenatal and labor records patient events such as urine test results, pushing efforts, assessments of respirations after administering Stadol, and results of any third trimester assessment for gestational diabetes. Respondent's lack of documentation demonstrates her lack of knowledge and skills and constitutes incompetence.

THIRTY-THIRD CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 33-27-24)

84. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating Code sections 2835 and 2836.1, and California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 33-27-24. The circumstances are as follows:

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A. The matters alleged in paragraphs 78 through 83 are realleged and incorporated herein by reference as though fully set forth.

B. Nurse practitioners are mandated to consult with supervising physicians when certain risk factors are present during the course of a normal pregnancy. The specific factors are usually included in the standardized procedures and/or protocols. They include a history of a previous c-section delivery, mitral valve prolapse, positive test results for ANA, and slower than usual progress of labor.

C. The standard of care to transfer the care of a patient to a different primary care provider is to consult first with the receiving physician. Respondent exceeded the scope of her practice when she transferred the care of this patient from her birthing center to SVH without first consulting with the on-call physician.

THIRTY-FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 06-47-70)

85. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1442, 1480 and 1485, in that she was grossly negligent in her care and treatment of Patient No. 06-47-70. The circumstances are as follows:

86. On July 22, 2004, respondent began providing prenatal care for Patient No. 06-47-70 and continued to practice medicine as a nurse practitioner on this patient until the patient was transferred to SVH on February 19, 2005, at 1600 hours. Respondent noted in the patient's prenatal care records the following significant medical factors: prior C-section delivery for placental abruption, prior pregnancy-induced hypertension, history of herpes simplex virus, history of an eating disorder, history of postpartum depression (currently being treated with Celexa), history of abnormal Pap smear results, hypothyroidism, rubella non-immune status, blood group and type A negative, vegetarian diet, and exposure to second-hand smoke from husband. The patient twice declined respondent's request to take a Pap smear. A smear was finally obtained on December 7, 2004. On November 1, 2004, the patient reported an outbreak of herpes virus. Respondent did not prescribe Valtrex to treat herpes simplex virus

prophyllactically until January 1, 2005. During the course of prenatal care respondent also prescribed Cleocin vaginal cream, Synthroid, Vicodin, and Ativan. During labor respondent administered Stadol three times and Toradol once. Respondent had no supervising physician and no standardized protocols and procedures developed with and pre-approved by a licensed physician at the time she provided prenatal and intrapartum care to this patient.

87. According to respondent's labor records, the patient was 3 cm dilated when she arrived at the birthing center at 1800 hours on February 18, 2005. The patient's membranes ruptured on February 19, 2005, at 0200 hours. Respondent administered Stadol to the patient at 0100 hours, 0230 hours, and 0500 hours on February 19, 2005. Respondent administered Toradol to the patient at 0300 hours on February 19, 2005. The patient's dilation progressed to 7 cm at 0245 hours, to 8-9 cm at 0400 hours and to 9 cm at 0600 hours. The patient's cervix failed to dilate further than 9 cm. She was transferred to SVH at 1500 on February 19, 2005. Respondent told the on-call physician that the patient was 9 cm dilated at 0400 hours but had failed to progress further. The hospital delivered the baby by cesarian section on February 19, 2005.

88. The Nurse Practice Act [NPA] requires all practicing nurse practitioners to have standardized procedures and/or protocols that have been developed by the nurse practitioner and a supervising physician to insure safe and competent patient care within the scope of practice for a nurse practitioner. Respondent's performance of medical interventions, provision of prenatal and labor care, and prescription and administration of medications without having standardized procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

89. Having documented that Patient No. 06-47-70 was a high risk patient because of her prior C-section delivery at 34 weeks gestation for placental abruption, respondent nonetheless agreed to provide a trial of labor for this patient at her free-standing birth center. The American College of Obstetricians and Gynecologists (AACOG) recommends attempting vaginal delivery after cesarean (VBAC) only if the patient has no previous rupture, a physician is immediately available who is capable of monitoring all active labor and of performing an

emergency c-section delivery, and anesthesia personnel are available for emergency c-section delivery. Respondent exceeded the scope of practice for a nurse and nurse practitioner by attempting a vaginal delivery at her birthing center of a high risk patient with a prior c-section delivery for placental abruption without having a licensed physician, surgical facility or anesthesia personnel immediately available. Her conduct was an extreme departure from the standard of care and constitutes gross negligence.

90. Nurse practitioners are trained and licensed to manage the care of normal pregnancies and to consult with supervising physicians when high risk factors are present. These factors are contained in the standardized procedures and protocols that the nurse practitioner and physician have agreed upon. Respondent placed the patient at greater risk of harm by failing to consult with a supervising physician regarding the risk factors she identified for this VBAC patient. Respondent's conduct was an extreme departure from the standard of care and constituted gross negligence.

THIRTY-FIFTH CAUSE FOR DISCIPLINE

(Incompetence: Patient No. 06-47-70)

91. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2725 and 2836.1, and California Code of Regulations, title 16, sections 1480 and 1485, in that she failed to accurately and comprehensively document the record of care for Patient No. 06-47-70. The circumstances are as follows:

A. The matters alleged in paragraphs 85 through 90 are realleged and incorporated herein by reference as though fully set forth.

B. Competent nursing requires a care plan with follow-up evaluations for each nursing diagnosis. Respondent failed to document care plans for the patient's history of pregnancy-induced hypertension, history of depression, vegetarian diet, exposure to secondhand smoke, Rh negative blood and hypothyroidism. Her failure to develop care plans and evaluate their success or need for revision put the patient at risk

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for developing more serious complications in pregnancy. The lack of care plans demonstrates respondent's lack of knowledge and skills and constitutes incompetence.

C. Respondent inappropriately prescribed Cleocin for a "white discharge," Vicodin for "groin" pain and Ativan for anxiety during early labor. Respondent's prescription of medications that do not meet the standard of care for pregnant patients demonstrates her lack of knowledge and skills and constitutes incompetence.

D. Accurate and complete documentation of patient events on the patient's medical record is a basic nursing standard. The documentation provides the evidence to support diagnoses and interventions. Respondent failed to document the results of this patient's thyroid panel, symptoms or other data that led to her decision to test, any pre-term symptoms at the time she decided to perform a test for susceptibility of pre-term labor, assessments of the patient's respirations and output or of the intravenous site during labor, and intravenous puncture procedure. Respondent's failure to document these significant events on the patient's chart demonstrate her lack of knowledge and skills and constitute incompetence.

E. Routine maternal assessment during active labor includes taking the maternal patient's vital signs every 30-60 minutes depending on the laboring woman's status, fetal assessments and institutional guidelines. The administration of narcotics such as Stadol requires more frequent assessment of the respirations because of the narcotic's effect on the central nervous system. Labor nurses routinely record all voiding and fluid input. Respondent's failure to document these routine assessments demonstrates her lack of knowledge and skill and constitutes incompetence.

F. Respondent's failure to consult with a physician regarding this high risk patient placed the patient at greater risk of harm. Respondent's provision of unsafe medical care for this high risk patient demonstrates her lack of knowledge and skills and constitutes incompetence.

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THIRTY-SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 32-64-12)

92. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1443, 1443.5, 1480 and 1485, in that she was grossly negligent in her care and treatment of Patient No. 32-64-12. The circumstances are as follows:

93. Patient No. 32-64-12 started receiving prenatal care from respondent at the birthing center on May 27, 2004. Prenatal care consisted of routine exams, prescription of medications and laboratory analyses. Respondent noted the patient had the following risks or problems: history of slipped disc, chlamydia infection, asthma, abnormal pap smear, laparoscopy to rule out endometriosis, bacturia in this pregnancy, allergy to sulfa, and family history of diabetes mellitus. Respondent treated this patient for UTI at least 4 different times. Respondent prescribed the following medications: Macrobid, Pulmicort, Albuterol, Singular, Cleocin vaginal cream and Ampicillin. The patient's prenatal records are missing care plans for all of the identified problems and evaluations of these plans, diagnosis to correspond to treatment provided on November 8, 2004, a physician consultation regarding urinary tract re-infections, and a plan to provide the patient with prophylaxis treatment.

94. Respondent's labor notes indicate the patient was 38 and 6/7 weeks pregnant and 5-6 cm dilated when she presented to the center at 0030 hours on November 26, 2004. At 0545 hours respondent artificially ruptured the patient's membranes. Respondent's records indicate she noted light meconium, a sign of fetal stress, in the fluid at 0600 hours, and that the patient remained 8 cm dilated from 0545 until 1530 hours. By 1730 the patient had progressed to 9cm dilated but was still at 9cm at 2315 hours. Respondent gave the patient Stadol at 0930 and 1630 hours; she gave the patient Toradol at 1230 and 1730 hours. Respondent was not being supervised by a licensed physician and did not have standardized procedures and protocols that she had developed with and had pre-approved by a licensed physician when she furnished the medications. Respondent performed 18 vaginal exams after the artificial rupture of membranes. The patient had no change in cervical dilation for 12 hours before she was

transferred to SVH at 2315 hours. At 0040 hours on November 27, 2004, the patient, unaccompanied by respondent, arrived at SVH with a copy of her records. The transfer notes stated the patient was transferred during second stage labor due to arrested second stage labor and failure of the fetus to descend. The transfer notes record one administration of Stadol but do not mention administration of Toradol. The transfer summary notes that respondent discussed the transfer with the on-call physician at SVH, but Dr. Kim's interview statement denies any conversation with respondent at that time. Respondent failed to accompany the patient to SVH and to give a verbal report of her labor progress to the on-call physician at SVH. The patient's baby was delivered by C-section at 0259 on November 27, 2004.

95. Respondent's performance of medical interventions, provision of prenatal and labor care, and prescription and administration of medications without having standardized procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

THIRTY-SEVENTH CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 32-64-12)

96. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 32-64-12. The circumstances are as follows:

A. The matters alleged in paragraphs 92 through 95 are realleged and incorporated by reference herein as though fully set forth.

B. Urine tests respondent had performed on this patient during prenatal care revealed three different bacteria. The patient should have been diagnosed with re-infections instead of simply "bacturia." The standard of care for treating recurrent or re-infections is suppressive therapy for the remainder of the pregnancy. Since the patient had no history of UTI's, she required not only medical treatment but also education on preventing future UTI's. Respondent's failure to treat and diagnose urinary tract re-

infections and her failure to teach the patient about preventing future UTI's and about recognizing symptoms of UTI's demonstrate her lack of knowledge and skills and constitute incompetence.

C. Respondent prescribed Cleocin vaginal cream for 7 days to treat Lactobacilli. Cleocin is used for more serious infections and is not recommended in pregnancy. Respondent's prescription of this drug demonstrates her lack of knowledge and skills and constitutes incompetence.

D. Respondent's failure to construct care plans for the problems she identified in this patient's pregnancy demonstrates her failure to apply the nursing process. By failing to develop care plans respondent could not evaluate the success or her treatments. The nursing process is a basic skill for all nurses, including nurse practitioners. Respondent's failure to use the nursing process demonstrates her lack of knowledge and skills and constitutes incompetence.

E. Respondent's failure to consider the patient's obesity and family history of diabetes mellitus led to her failure to identify the patient as high risk for gestational diabetes. Gestational diabetes is associated with excessive fetal growth which may result in birth trauma. The standard of care is to test early in the pregnancy for gestational diabetes. Respondent's failure to identify these risks and test for them early in the pregnancy demonstrates her lack of knowledge and skills and placed her patient at risk for severe complications in pregnancy. Respondent's conduct constituted incompetence and gross negligence.

THIRTY-EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 32-64-12)

97. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, sections 1480 and 1485, in that she failed to consult with a supervising physician when problems arose in the pregnancy of Patient No. 32-64-12 that required another level of expertise. The circumstances are as follows:

A. The matters alleged in paragraphs 92 through 96 are realleged and incorporated by reference herein as though fully set forth.

B. Nurse practitioners are trained and licensed to manage the care of normal pregnancies. A physician consultation or referral is the standard of care for pregnant women who have urinary tract re-infections within 2 weeks or who grow the original pathogen on follow-up urine cultures. Respondent's failure to consult with a supervising physician when the patient presented with health conditions outside of respondent's scope of practice as a nurse practitioner constitutes gross negligence.

THIRTY-NINTH CAUSE FOR DISCIPLINE

(Incompetence: Patient No. 32-64-12)

98. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code sections 2725 and 2836.1, and California Code of Regulations, title 16, sections 1443, 1443.5, 1480 and 1485, in that she failed to accurately and comprehensively document the record of care for Patient No. 32-64-12. The circumstances are as follows:

A. The matters alleged in paragraphs 92 through 97 are realleged and incorporated by reference herein as though fully set forth.

B. Documentation of patient events is a basic nursing standard. Respondent failed to document patient respirations after administering Stadol, an assessment of the intravenous site, patient output throughout the labor process, and the administration of Toradol and the first dosage of Stadol on the transfer summary. Respondent's failure to accurately and comprehensively document patient events demonstrates her lack of knowledge or skill and constitutes incompetence.

FORTIETH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 32-15-14)

99. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1442, 1443

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and 1443.5, in that she was grossly negligent in her care and treatment of Patient No. 32-15-14. The circumstances are as follows:

100. On May 11, 2004, respondent began providing prenatal care for this 24 year old patient at her birthing center, The Whole Woman, Inc., located at 2950 North Sycamore Drive in Simi Valley, California. The patient was 32 weeks pregnant with an estimated delivery date of July 14, 2004. She had an unremarkable medical history and a family history of twin gestations. Respondent's Midwifery Care Checklist indicates she reviewed the back-up OB physician and OB Care Pre-Authorization with the patient. No back up physician is named in the record. At the first prenatal visit respondent recorded the patient's fundal height at equal to 34 weeks gestation. The patient's urine culture from May 11, 2004, tested positive for Group B Streptococcus [GBS]. Respondent did not document the genital culture results or a plan of care for the positive urine test result. On June 19, 2004, respondent performed a vaginal exam and an in-house urinalysis. She diagnosed the patent with a urinary tract infetion [UTI] and prescribed and dispensed Amoxicillin 250 mg for 7 days and prescribed Vicodin 5/500 for UTI pain. She then sent the patient home.

101. Respondent's labor notes indicate the patient arrived at the birthing center on June 20, 2004, with irregular "UC's" [uterine contractions], 2-3 cm dilated, 50% effaced and -1 station (as revealed by cervical exam). At 0200 hours the patient was sent home. The patient returned at 0715 hours on June 21, 2004. According to respondent's notes, she was 3-4 cm dilated, 70% effaced, and -1 station with irregular UC's. The patient was sent home again but returned at 2330 hours reporting spontaneously ruptured membranes [SROM]. Respondent administered Clindamycin by intravenous [IV]. At 1500 hours on June 22, 2004, respondent administered Stadol and Toradol by IV. Respondent performed a vaginal exam and noted the client was 9 cm dilated, completely effaced and +1 station. Respondent did not document patient output or an IV start or site assessment on the labor record. After four hours with no further progress, respondent transferred the patient to Simi Valley Hospital [SVH]. Respondent's transfer notes state the reason for transfer was the patient's complaints of pain. Respondent gave

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the report to the labor and delivery RN. The record does not record any report made to the SVH physician on call. SVH delivered a viable female infant by C-section at 2053 on June 22, 2004.

102. Respondent's performance of medical interventions, provision of prenatal and labor care, and prescription and administration of medications without having standardized procedures and/or protocols that she had developed with a supervising physician was an extreme departure from the standard of care and constituted gross negligence.

FORTY-FIRST CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence: Patient No. 32-15-14)

103. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1442, 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge and was grossly negligent in her care and treatment of Patient No. 32-15-14. The circumstances are as follows:

A. The matters alleged in paragraphs 99 through 102 are realleged and incorporated by reference herein as though fully set forth.

B. The standard of care for antepartum GBS positive cultures is Amoxicillin for 7 days. Respondent failed to document her treatment of the diagnosis, to record a plan of care during the pregnancy and labor, or to note whether the patient had any allergies.

C. The standard of care for intrapartum antibiotic therapy for a positive GBS urine culture is penicillin or ampicillin by IV every 4 hours until delivery. Clindamycin or erythramicin may be administered if the patient is allergic to penicillin treatment. Competent nursing requires a nursing care plan to be implemented for each diagnosis. The care plan is comprised of a nursing diagnosis, formulation of a care plan, and implementation and evaluation of that plan.

D. Respondent's records indicate she first gave the patient Amoxicillin on June 19, 2004, and first gave the patient Clindamycin on June 22, 2004.

D. Respondent's delay in treating a known infection was an extreme

departure from the standard of care and constituted gross negligence and incompetence. The delay put the patient at risk for severe consequences of UTI, which pregnant women are more likely to develop with UTI's are present.

FORTY-SECOND CAUSE FOR DISCIPLINE

(Incompetence: Patient No. 32-15-14)

104. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge in her care and treatment of Patient No. 32-15-14. The circumstances are as follows:

A. The matters alleged in paragraphs 99 through 103 are realleged and incorporated by reference herein as though fully set forth.

B. On June 19, 2004, respondent diagnosed the patient's UTI, documented labor pains, and prescribed antibiotics and Vicodin for "UTI pain." The standard of care for treating UTI pain is antispasmodic medication. Vicodin is generally reserved for us with patient complaints of muscular, skeletal or other types of chronic pain.

C. Respondent's treatment for UTI pain demonstrates her lack of skills and knowledge and constitutes incompetence.

FORTY-THIRD CAUSE FOR DISCIPLINE

(Incompetence: Patient No. 32-15-14)

105. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1443, 1443.5, 1480 and 1485, in that she failed to demonstrate competent skills and knowledge in her care and treatment of Patient No. 32-15-14. The circumstances are as follows:

A. The matters alleged in paragraphs 99 through 104 are realleged and incorporated by reference herein as though fully set forth.

B. Respondent failed to identify the following patient problems: family history of twin gestations, size greater than dates on first exam, and failure to progress in labor. Respondent failed to order an obstetrical ultrasound, perform a pelvic exam during

the first prenatal visit and to document pregnancy dating criteria other than the patient's last menstrual period date. Respondent's failure to apply the nursing process, demonstrated by her failure to identify problems in the patient's pregnancy, her failure to formulate a care plan for the identified problems in the patient's pregnancy, to perform essential skills, and to evaluate the effectiveness of the care demonstrate a lack of knowledge and skills and constitute incompetence.

FORTY-FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence: Patient No. 32-15-14)

106. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for violating California Code of Regulations, title 16, sections 1443, 1443.5, 1480 and 1485, in that she was grossly negligent in her care and treatment of Patient No. 32-15-14. The circumstances are as follows:

A. The matters alleged in paragraphs 99 through 105 are realleged and incorporated by reference herein as though fully set forth.

B. As the "primary health care" provider for this patient's pregnancy, respondent was responsible for the continuity of health care regardless of the presence or absence of disease. Respondent failed to consult with a physician when high risk conditions were present and failed to communicate directly with the hospital's on-call physician when she transferred the patient's care. The hospital records note that the patient's birth center records were faxed to them after the patient's baby had been delivered by C-section and more than two hours after the patient had been transferred. Respondent's failure to consult with a physician, to communicate with the hospital's on-call physician, and to provide necessary information regarding the patient's medical history during a medical crisis could have jeopardized the lives of the mother and baby. Respondent's conduct was an extreme departure from the nursing standards of care and constituted gross negligence.

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FORTY-FIFTH CAUSE FOR DISCIPLINE

(Falsification and Grossly Incorrect Statements in Patient Records: Patient No. 32-15-14)

107. Respondent is subject to disciplinary action under sections 2761, subdivisions (a)(1) and (d), 2762, subdivision (a), for violating Code section 2836.1, and California Code of Regulations, title 16, section 1442 in that she dishonestly, fraudulently and deceitfully documented in the records of Patient No. 32-15-14 that she had a supervising or back-up physician and inaccurately recorded when the patient's labor started. The circumstances are as follows:

A. The matters alleged in paragraphs 99 through 106 are realleged and incorporated by reference herein as though fully set forth.

B. Respondent noted in the patient's birthing center chart that she had told her she had a "back-up OB," when she had no physician supervising her. One of the qualifications for a nurse to present herself as a nurse practitioner is to have secured a supervising physician before practicing medicine. Patients have a right to full disclosure of a nurse practitioner's qualifications. Respondent's deceitful misrepresentation of her qualifications is an extreme departure from the standard of care and constitutes gross negligence.

C. Respondent recorded on the patient's prenatal record that her labor started on June 19, 2004; respondent noted on the patient's labor record that labor started on June 21, 2004. Inaccurate information in patient's records can jeopardize the patient's health. Respondent's inaccurate recording of the onset of the patient's labor is an extreme departure from the standard of care and constituted gross negligence.

FORTY-SIXTH CAUSE FOR DISCIPLINE

(Incompetence: Patient No. 32-15-14)

108. Respondent is subject to disciplinary action under sections 2761, subdivision (a)(1), and 2762, subdivision (a), for violating Code section 2725, and California Code of Regulations, title 16, sections 1443, 1443.5, 1480 and 1485, in that she failed to

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demonstrate competent skills and knowledge in her care and treatment of Patient No. 32-15-14. The circumstances are as follows:

A. The matters alleged in paragraphs 99 through 107 are realleged and incorporated by reference herein as though fully set forth.

B. Failure to accurately and comprehensively document patient events can jeopardize a patient's safety and health. Respondent failed to document GBS genital culture results; respirations after administration of Stadol, a narcotic drug that affects the central nervous system; intravenous start procedure; assessments of intravenous site; and urinary output during labor. Respondent's failure to document these patient events demonstrates her lack of knowledge and skills and constitutes incompetence.

FORTY-SEVENTH CAUSE FOR DISCIPLINE

(Furnishing or Ordering Controlled Substances or Dangerous Drugs without Standardized Procedures and Protocols)

109. Respondent is subject to disciplinary action under Code sections 2761, subdivision (a)(1)(unprofessional conduct), 2762, subdivision (a), for violating Code section 2836.1, subdivisions (a), (b), (c), (d), (f), (g) and (h) (nurse practitioner functioning pursuant to standardized procedures) in that she prescribed or furnished dangerous drugs and/or controlled substances to patients without having standardized procedures and protocols developed with and approved by a supervising physician. The circumstances are set forth more fully in paragraphs 28 through 108 above and incorporated herein as though set forth in full.

FORTY-EIGHTH CAUSE FOR DISCIPLINE

(Furnishing or Ordering Dangerous Drugs or Controlled Substances without Being Supervised by a Licensed Physician)

110. Respondent is subject to disciplinary action under Code sections 2761, subdivision (a)(1)(unprofessional conduct), 2762, subdivision (a), for violating Code section 2836.1, subdivisions (d), (f) and (h) (nurse practitioner furnishing or ordering drugs) in that she prescribed or furnished dangerous drugs and/or controlled substances to patients without being

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supervised by a licensed physician. The circumstances are set forth more fully in paragraphs 28 through 109 above and incorporated herein as though set forth in full.

FORTY-NINTH CAUSE FOR DISCIPLINE

(Prescribing or Furnishing Drugs without Being So Directed by Physician)

111. Respondent is subject to disciplinary action under Code sections 2761, subdivision (a)(1)(unprofessional conduct), and 2762, subdivision (a) (prescribing or furnishing controlled substances or dangerous drugs to self or others without being directed to do so by licensed physician) in that she prescribed or furnished dangerous drugs and/or controlled substances to patients or herself without being directed to do so by a licensed physician. The circumstances are set forth more fully in paragraphs 28 through 110 above and incorporated herein as though set forth in full.

FIFTIETH CAUSE FOR DISCIPLINE

(Suspension of License by Another California Health Care Licensing Board)

112. Respondent is subject to disciplinary action under Code section 2761, subdivisions (a)(1) and (4), for having her license, issued by the Medical Board of California, to practice midwifery suspended. The circumstances are that on March 1, 2007, the Medical Board of California obtained an Interim Suspension Order against respondent's Licensed Midwife Certificate number LM 134. The order specifically prohibits respondent from providing any patient care. Respondent's license to practice midwifery will remain suspended until the Medical Board's decision on the related accusation becomes final.

FIFTY-FIRST CAUSE FOR DISCIPLINE

(Practicing Nursing without a Valid License)

113. Respondent is subject to disciplinary action under Code section 2761, subdivisions (a), (d) and (j), for violating sections 2795 and 2732 (practicing nursing without a valid license). The circumstances are as follows:

114. On January 25, 2007, as set forth more fully in paragraph 41 below above and incorporated herein by reference as though set forth in full, respondent was served with an order suspending her license and certificates to practice nursing in the State of California. On

March 1, 2007, as set forth more fully above and incorporated herein by reference, the Medical Board of California obtained an Interim Suspension Order against respondent's license, issued by that board, to practice midwifery. On or about March 14, 2007, a search warrant was executed on respondent's premises known as The Whole Woman, Inc., at 2950 North Sycamore Drive in Simi Valley. The search warrant was based in part upon a consumer complaint about respondent's practice of midwifery. Evidence obtained during and following the execution of the search warrant indicated respondent continued to provide nursing services at her business, The Whole Woman Inc., after the interim suspension order was in effect. The nursing services respondent provided include but are not limited to the prescription of Ampicillin on March 5, 2007, for Whitney S.

FIFTY-SECOND CAUSE FOR DISCIPLINE

(Misleading Advertising)

115. Respondent is subject to disciplinary action under Code section 2761, subdivisions (a)(3) and (d), for advertising herself as a registered nurse and nurse practitioner in violation of Section 17500. The circumstances are that after the January 23, 2007 suspension order became effective, respondent's website, www.thewholewomaninc.com, continued to represent respondent as a Nurse Practitioner.

FIFTY-THIRD CAUSE FOR DISCIPLINE

(Violation of Interim Suspension Order)

116. Respondent is subject to disciplinary action under sections 2761, subdivisions (a) and (d), and 494, subdivision (i), in that she violated the Interim Suspension Order issued on January 23, 2007, and served on January 25, 2007, following the January 19, 2007 ex parte hearing. In addition to suspending all of respondent's nursing licenses pending the final outcome of the noticed hearing on the Petition for Interim Suspension Order, the January 23, 2007 interim suspension order directed respondent not to:

A. "Practice or attempt to practice any aspect of nursing in the State of California until the final decision of the Board following an administrative hearing;

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B. Be present in any location which is maintained for the purpose of nursing, or at which nursing is practiced, for any purpose, except as a patient;

C. Advertise, by any means, or hold herself out as practicing or available to practice nursing."

117. The Interim Suspension Order further directed:

"Respondent shall, no later than 12:00 p.m. on January 29, 2007, deliver to the Board, or its agent, for safekeeping pending a final administrative order of the Board in this matter, all indicia of her licensure as a registered nurse, and her certification as a public health nurse, as a nurse practitioner, and as a nurse practitioner furnisher, including but not limited to, her wall certificate(s) and wallet card(s) issued by the Board."

118. Following a February 13, 2007 hearing of respondent's motion for a continuance of the noticed hearing on the petition for interim suspension order, respondent was ordered to "comply with the order to deliver her indicia of licensure [to the Board] by February 23, 2007."

119. On March 15, 2007, following the March 13, 2007 noticed hearing on the petition for interim suspension order, respondent was ordered to deliver to the Board or its agent "no later than 12:00 p.m. on **March 22, 2007**, . . . for safekeeping pending a final administrative order of the Board in this matter, all remaining indicia of her licensure as a registered nurse, and her certifications as a public health nurse, as a nurse practitioner and as a nurse practitioner furnisher, including, but not limited to, her wall certificate(s) and wallet card(s) issued by the Board. **Framed wall certificates must either be disassembled and the unframed certificates delivered to the Board, or the wall certificates must be delivered to the Board in their frames, whichever method respondent chooses.**" (Emphasis original.)

120. Respondent has violated the Interim Suspension Order directing her not to practice or attempt to practice any aspect of nursing in the State of California until the final decision of the Board following an administrative hearing. The circumstances are that, from on or about January 26, 2007, to on or about March 28, 2007, respondent prescribed dangerous drugs and or controlled substances to patients whose names are known to respondent but not

known to complainant. The prescriptions include, but are not limited to, a prescription issued on or about March 5, 2007, to Whitney S. for Ampicillin 250 mg.

121. Respondent has violated the Interim Suspension Order directing her not to be present in any location which is maintained for the purpose of nursing, or at which nursing is practiced, for any purpose, except as a patient. The circumstances are set forth in paragraph 45 above and incorporated herein as thought set forth in full.

122. Respondent has violated the Interim Suspension Order directing her not to advertise, by any means, or hold herself out as practicing or available to practice nursing. The circumstances are as follows:

a. Respondent's issuance of prescriptions as set forth more fully in paragraph 45 above are incorporated herein as though set forth in full.

b. In addition, respondent's website, www.thewholewomaninc.com, continues to advertise that she is a licensed Nurse Practitioner.

123. On three separate occasions – January 29, 2007, February 23, 2007, and March 22, 2007 – respondent has violated the Interim Suspension Order directing her to deliver to the Board of its agent all indicia of her licensure as a registered nurse as well as her certifications as a public health nurse, nurse practitioner and nurse practitioner furnisher.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 429440, issued to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen Marcia Kay McCulley;

2. Revoking or suspending Nurse Practitioner Certificate No. 9598, issued to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen Marcia Kay McCulley;

3. Revoking or suspending Nurse Practitioner Furnisher Certificate No. 9578, issued to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen Marcia Kay McCulley;

4. Revoking or suspending Public Health Nurse Certificate No. 49428, issued to respondent Marcia Kay McCulley a.k.a. Marcia Kay Hansen Marcia Kay McCulley;

5. Ordering Marcia Kay McCulley to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

6. Taking such other and further action as deemed necessary and proper.

DATED: 8/14/07

Elliot Hochberg for
RUTH ANN TERRY, M.P.H, R.N
Executive Officer
Board of Registered Nursing
State of California
Complainant

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